IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION TO DISMISS No. 75-1691 BASED UPON MOOTNESS
MOTION TO AFFIRM No. 75-1698 BASED UPON INTERVENING CIRCUMSTANCES

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Pursuant to Rule 35 of this Court, appellees file the within Motions to Dismiss and Affirm to present, prior to argument, intervening matters that were not available in time to have been included in the Brief of Appellees filed on December 22, 1976, which intervening matters make appropriate the dismissal of the appeal in No. 75-1691 and the affirmance of the appeal in No. 75-1698.

1. Motion to Dismiss No. 75-1691 Based Upon Mootness.

The only issue presented by the Jurisdictional Statement of appellants in No. 75-1691 is the claimed right of hospitals represented by the Delaware Valley Hospital Council to contract with Blue Cross subscribers in connection with hospital admissions during the period August 15, 1974 to August 2, 1975 and during the period of approximately 13 months subsequent to August 2, 1975, rather than being required to "contract" with appellee Blue Cross of Greater Philadelphia for hospital admissions during such periods.

On October 18, 1976 appellee Pennsylvania Insurance Department gave its approval (Exhibit A hereto) to a form of contract between appellants in No. 75-1691 and appellee Blue Cross. By interpretive letter dated November 17, 1976, said form of Blue Cross-

hospital contract was forwarded to the hospital parties (Exhibit B hereto). Such contract (Exhibit C hereto) was executed by all appellants in No. 75-1691 and by appellee Blue Cross on December 30, 1976, and is now in full force and effect.

The 1976 Blue Cross-hospital contract provides in pertinent part:

> "This Agreement shall commence on July 1, 1976 and expire on June 30, 1978, provided however, that if Act 94 of 1975 is no longer applicable to the termination of this Agreement it shall be automatically extended through June 30, 1979. This Agreement shall supersede all previous agreements between the parties hereto, although it is expressly agreed that the 1971 Hospital Agreement [exclusive of certain "hold down" provisions thereof] . . . shall apply to all admissions during the period July 1, 1974 [*i.e.*, the earliest date suggested by appellants as the expiration date of the 1971 Hospital Agreement] to June 30, 1976, inclusive . . ."

Section 21.1 (*infra* p. 37a). See also Section 21.2 (*infra* p. 37a), Exhibit B hereto (*infra* pp. 5a-6a), and Section 1.10-1.12 of Exhibit A to the 1976 Hospital Agreement (*infra* pp. 66a-69a).

By the terms of the 1976 Hospital Agreement quoted immediately above, appellants have now agreed that admissions during the two periods in controversy will be accounted for on the basis of a contract between Blue Cross and the hospitals. Thus, there would appear to be no relief to which appellants are entitled in view of their settlement of the controversy, and there is therefore no case or controversy before this Court.

2. Motion to Affirm No. 75-1698 Based Upon Intervening Circumstances.

Appellants in No. 75-1698 have appealed to this Court along with appellants in No. 75-1691 from an order denying, after notice and hearing, an injunction in a civil action, challenging the constitutionality of an Act of the Commonwealth of Pennsylvania (Act No. 94), required by Act of Congress to be heard and determined by a district court of three judges. 28 U.S.C. §§ 1253, 2281.

The appeal in No. 75-1698 raises an issue relating to certain contracts which were in existence on the August 2, 1975 effective date of Act No. 94, which issue is not affected by the 1976 Hospital Agreement executed by appellants in No. 75-1691. Thus, the appeal in No. 75-1698 is not moot, and appellants in No.

75-1698 retain their statutory right of direct appeal to this Court.

However, the difficult constitutional issue in the combined appeals in Nos. 75-1691 and 1698 is the validity of Act No. 94 as applied retroactively to hospital admissions prior to August 2, 1975, and such issue is confined to the appeal, now moot, in No. 75-1691. Accordingly, the mootness of the appeal in No. 75-1691 constitutes an intervening circumstance making the questions on which the decision of the remaining cause depends so unsubstantial as not to need further argument. See Rules 15(1)(f) and 16(1)(c).

3. Relief Requested.

The established practice of this Court in dealing with a civil case such as No. 75-1691 from a court in the federal system which has become moot pending review by the Court is to reverse or vacate the judgment below and remand with a direction to dismiss. *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39 (1950). However, such a step would not be appropriate in the instant situation, since a dismissal of the case by the lower court would deprive appellants in No. 75-1698 of the basis for their appeal to this Court. Accordingly, appellants would respectfully suggest that this Court dismiss only the appeal in No. 75-1691 as moot, and that the Court enter an

order vacating only so much of the order below as applies to appellants in No. 75-1691.*

4. Further Information.

On December 30, 1976, counsel for appellees contacted counsel for appellants in No. 75-1691 by telephone with the suggestion that the cause in No. 75-1691 be disposed of by an agreement to dismiss under Rule 60(1), and with the offer to settle the costs issue under said Rule by having appellants and appellees absorb the costs which they had respectively incurred thus far (recognizing that appellees would be entitled to recover from appellants in No. 75-1698 the costs applicable to the appeal in No. 75-1698 if the judgment in that case were to be affirmed). On January 6, 1977, a draft copy of a Suggestion of Mootness was served on counsel for appellants. Although there have been communications between counsel in the interim, no agreement to dismiss under Rule 60(1) has been reached.

In the interests of bringing the aforesaid settlement in No. 75-1691 promptly to the attention of this Court

* If appellees fully prevail in their within motions an appropriate disposition in this Court would be: (1) to affirm the judgment of the district court insofar as it relates to the controversy between appellees on the one hand and The Williamsport Hospital and The Hospital Association of Pennsylvania (appellants in No. 75-1698) on the other, and (2) to vacate the judgment of the district court insofar as it relates to the controversy between appellees on the one hand and the balance of the plaintiffs below (appellants in No. 75-1691) on the other, with direction to dismiss the action as to all such parties in No. 75-1691.

in light of the present status on the calendar of Nos. 75-1691 and 1698, appellees have accordingly submitted the within Motions to Dismiss and Affirm under Rule 35.

Respectfully submitted,

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Of Counsel:
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Exhibit A

INSURANCE DEPARTMENT
Harrisburg

(Letterhead)

October 18, 1976

David S. Markson, Vice President
and Corporate Secretary
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA 19107

Dear Mr. Markson:

Re: SUPPLEMENT TO BLUE CROSS FILINGS No. 2-P-76
AND No. 3-P-76

We are approving the captioned supplement which consists of the final agreement negotiated with certain hospitals represented by the Delaware Valley Hospital Council. A copy of the agreement bearing our approval stamp is enclosed for your file purposes.

Very truly yours,

/s/ JACOB A. LAZERSON

JACOB A. LAZERSON, Actuary
Bureau of Regulation of Rates
and Policies

Exhibit A

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

September 1, 1976

Hon. William J. Sheppard
Insurance Commissioner
Pennsylvania Department of Insurance
Finance Building—Room 108
Harrisburg, Pennsylvania 17120

Re: SUPPLEMENT TO BLUE CROSS FILINGS No. 2-P-76 AND No. 3-P-76

Dear Commissioner Sheppard:

As you will recall, on June 1, 1976 we formally amended our Filings No. 2-P-76 and No. 3-P-76 which were originally filed on April 28, 1976. In our amendment of June 1, 1976 we submitted to you a draft form of a newly negotiated Agreement for certain hospitals represented by the Delaware Valley Hospital Council. As we indicated to you in that letter of June 1, 1976 and in our previous letter of May 26, 1976, certain minor matters, principally of a nonsubstantive nature, would be negotiated and the finalized Agreement would be submitted to you by way of supplement.

Enclosed herewith please find two copies of the final version of the Agreement referred to in our letters of June 1, 1976 and May 26, 1976. We respectfully request your prompt approval of this supplement consisting of the finalized Agreement.

Exhibit A

We are also enclosing two copies of this letter so that your approval may be noted thereon and one copy returned for our file.

Respectfully yours,

/s/ DAVID S. MARKSON

DAVID S. MARKSON
Vice President and
Corporate Secretary

Approved, Effective 10/18/76
PENNSYLVANIA INSURANCE DEPARTMENT
By /s/ JACOB A. LAZERSON

Exhibit B

MORGAN, LEWIS & BOCKIUS

(Letterhead)

November 18, 1976

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: 1976 HOSPITAL AGREEMENT

Dear Mr. Abbott:

Enclosed herewith is a copy of the letter transmitted by Blue Cross of Greater Philadelphia to the various hospitals listed on page 9 of the subject agreement. In accordance with our prior discussions it has been agreed that your firm, as counsel to the plaintiffs in *Riddle Memorial Hospital, et al.* v. *Blue Cross of Greater Philadelphia*, No. 2187, October Term 1976, will immediately file with the Clerk of the Superior Court of Pennsylvania a praecipe withdrawing their appeal. In so acting it is understood and agreed by the parties thereto that the withdrawal of the appeal shall not limit the rights of any party to this litigation or any other person to challenge the validity of the assignment prohibition clause in Blue Cross subscriber agreements at any time in the future, and accordingly, the parties agree that the Declaratory Judgment issued in *Riddle Memorial Hospital et al* v. *Blue Cross of Greater Philadelphia* (Delaware County, Number 1667 of 1975) shall not be asserted by any party, its successors or assigns, as *res judicata* or collateral estoppel in any subsequent litigation involving future assignments of Blue Cross benefits. This settlement does not preclude either party from relying upon the above-captioned decision as precedent in support of its position

Exhibit B

in any future litigation involving assignment of Blue Cross benefits.

In order that we may close our files with regard to the *Riddle* litigation, please forward a copy of the praecipe withdrawing the appeal to the undersigned at your earliest opportunity. Thank you for your kind cooperation and assistance in bringing this matter to a successful conclusion.

Very truly yours,

/s/ ALLEN W. STEWART

ALLEN W. STEWART

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

November 17, 1976

Transmitted herewith are three copies of the 1976 Hospital Agreement which has received the approval of the Pennsylvania Insurance Department. After this contract has been approved by your institution, please return two executed copies to the undersigned. At such time, and as a condition precedent to Blue Cross' acceptance of the Agreement, at least 90% of the hospitals being offered this contract have returned executed copies (which hospitals are identified on pages A-9 and A-10 to Exhibit A of the Agreement), Blue Cross will deliver a fully executed copy of the Agreement for your files.

Since several questions have been raised with regard to the application of subsection 21.2 of the Agreement, counsel for both the hospitals being offered this contract and Blue Cross, have agreed that this provision shall be interpreted as described below, and your execution and de-

Exhibit B

livery of the Agreement to Blue Cross shall be considered as your acceptance of, and agreement to be bound by, said interpretation.

> Subsection 21.2 shall be construed to provide that in making final settlement for fiscal years 1975 and 1976, all indemnity payments made by Blue Cross to Subscribers on account of Covered Services furnished by the Provider during the period the Provider was a "Nonmember Hospital," as defined in their respective Subscription Agreements, shall be deducted from allowable costs for such fiscal years. If, after a reasonable collection effort has been made (as defined in the now current Medicare regulations), a hospital is unable to recover a portion of the indemnity payments made to Subscribers, Blue Cross shall credit against the aforesaid deduction from allowable costs a sum equal to one half of the uncollected amount of such indemnity payments; provided, however, the total amount to be credited all hospitals contracting under the Agreement shall not exceed $300,000.

In the event the total credit, determined as above, exceeds $300,000, the credit shall be recomputed so as to distribute such *pro rata* to all contracting hospitals. The foregoing credit shall be paid by Blue Cross at such time as final settlement is made for all affected hospitals.

This letter has been reviewed and approved by counsel to the Delaware Valley Hospital Council and I trust you will find such satisfactory. We look forward to working with you in the future.

Very truly yours,

Howard W. Baker, M.D.
Vice President

Exhibit C

HOSPITAL AGREEMENT
July 1, 1976
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Exhibit C

HOSPITAL AGREEMENT

The undersigned hospital (hereinafter called the "Provider") and Blue Cross of Greater Philadelphia (hereinafter called "Blue Cross"), intending to be legally bound, hereby enter into this Agreement. As part of its undertaking, Blue Cross agrees on behalf of each subscriber to the Hospitalization Plan of Blue Cross, Health Service, Incorporated or other Hospital Service Plan as designated and approved by Blue Cross (hereinafter called "Subscriber") to make those payments required hereinafter and provide its assistance to all area health care institutions in developing procedures and practices to further the goal of a consumer-responsive health care delivery system. The Provider agrees to utilize its best efforts to provide a viable and economical health care delivery system to satisfy the medical needs of the community which it serves.

Section 1. Provider Services and Facilities.

In consideration of the agreement by Blue Cross to reimburse the Provider as hereinafter described, the Provider agrees:

1.1. To furnish, as applicable, to each Subscriber those hospital services and facilities whereby there may be administered certain medical services incident to hospitalization of the type which Blue Cross is obligated to provide Subscribers (hereinafter called "Covered Services").

1.2. Covered Services shall be available to each Subscriber beginning with the effective date of his Subscription Agreement with Blue Cross (hereinafter called "Subscription Agreement"), except that any waiting periods specified therein may be modified or waived by Blue Cross in such cases as it may determine.

Exhibit C

1.3. Covered Services shall be provided to each Subscriber without an advance deposit or charge therefor to the Subscriber except to the extent of any co-payment or deductible amount provided in his Subscription Agreement, and that, except as aforesaid, Provider will accept the reimbursement provided for herein as the full contract payment of Blue Cross for such Covered Services.

1.4. Its charges for all services to Subscribers shall be the same as its charges to all patients for the same services. The Provider shall file a current schedule of such charges with Blue Cross and furnish written notice to Blue Cross of any modification of such charges at least five days prior to the effective date of such modification.

Section 2. Reimbursement by Blue Cross.

Blue Cross agrees to reimburse the Provider for Subscriber admissions on or after the effective date of this Agreement for those Covered Services furnished to Subscribers upon receipt of the medical records, if requested, and bills therefor, as follows:

2.1. Reimbursement will be made in accordance with the terms and conditions set forth in Exhibit A attached hereto and made a part hereof, except as otherwise provided herein.

2.2. If Covered Services are furnished as stated dollar allowances or indemnities, except for private room accommodations and indemnities for certain services of physicians, payment of such allowance or indemnity shall constitute final payment by Blue Cross and such Covered Services shall be excluded from any reimbursement calculation required by Exhibit A hereof although such reimbursement shall not preclude Provider from collecting the balance of its charges for such Covered Services from Subscribers.

Exhibit C

2.3. If all or any part of the Covered Services provided Subscribers admitted on or after the effective date of this Agreement is ultimately determined not to be medically appropriate as a result of formal medical review, the Provider shall not charge either Blue Cross or the Subscriber for the medically inappropriate portion of such services. For the purposes of making the foregoing determination, Blue Cross shall advise the Provider's Utilization Review Committee of any case which it has determined not to be medically appropriate. If the Utilization Review Committee concurs with Blue Cross, such determination will be deemed conclusive unless the attending physician or a consulting physician appeals, or if upon review the representatives of Blue Cross and Provider's Utilization Review Committee cannot reach a mutually agreeable result as to a given case, then such case shall be referred, at the expense of Blue Cross, to the appropriate committee of the Philadelphia County or State Medical Society or State Osteopathic Medical Association (or such county committee as shall hereafter be created and approved by the Provider and Blue Cross), as applicable, for its determination as to the medical appropriateness of the services in question. It is agreed that the determination of such medical society shall be binding upon both Blue Cross and Provider. If all or any part of a given hospital admission or length of stay is determined not to have been medically appropriate as a result of the foregoing review procedure, but medically appropriate services were furnished which should have been provided on an outpatient basis, Blue Cross shall reimburse Provider for any such Covered Services on an outpatient basis to the extent provided in the Subscriber's Subscription Agreement. However, if the Subscriber insists on hospitalization against the advice of his physician, the Provider may charge any unreimbursed charges to the

Exhibit C

Subscriber, provided, the Provider has supplied appropriate written evidence to Blue Cross that the Subscriber has been advised of his financial responsibilities.

2.4. For the purposes of the foregoing, the term "medical appropriateness" shall be interpreted to mean:

1. Hospitalization which is provided at the situs level furnishing necessary Covered Services at the lowest cost consistent with the services rendered.

2. Hospitalization limited in scope and extent to that medically justified by diagnosis and particular patient's condition.

3. Hospitalization limited in length of stay to that required by the patient's diagnosis as reviewed and approved by the Utilization Review Committee.

4. Hospitalization which is medically required and consistent with the requirements of the: (a) Public Law 89-97, as amended by P.L. 92-603, (b) Pre-Discharge Utilization Review Program of the Commonwealth of Pennsylvania for recipient's under Title XIX of the Medicaid Program, (c) Pennsylvania Department of Public Welfare as promulgated in the Welfare Assistance Manual at Section 9421.52 and (d) Joint Commission on Accreditation of Hospitals.

Section 3. Utilization Review.

The Provider shall maintain or create and maintain, as appropriate, a program of utilization review which satisfies the standards of either the Basic or Advanced Utilization Review Programs described below. If during the term of this Agreement the Provider desires to change Programs it shall give thirty (30) days prior written notice to Blue Cross.

Except as provided in subsections 3.2.1 and 3.2.2, the Provider shall forward to the Reimbursement Review Committee (RRC) for approval the Utilization Review Plan which it will employ to satisfy the requirements of this Section, as well as any subsequent changes thereto with a copy of such plan to be forwarded to Blue Cross.

3.1. The Basic Utilization Review Program.

The Provider shall appoint a Utilization Review Committee whose membership includes the Provider's Administrator or his designee, and at least one non-physician member of its governing board. The Committee shall be responsible for developing and implementing a program of utilization review.

3.1.1. *Scope of Program.* The Provider will strive to improve the effectiveness of its procedures for utilization review by exerting special efforts in reviewing:

(a) Lengths of stay;

(b) Promptness of service;

(c) Medical necessity of admissions;

(d) Use of consultations;

(e) Implementation of effective discharge planning; and

(f) Such other matters and procedures as will minimize the unnecessary use of expensive medical resources while ensuring proper patient care.

3.1.2. *Review of Admissions.* The Provider shall have all hospitalizations, whether elective or not, reviewed by the Utilization Review Committee within two (2) working days (excluding Saturday, Sunday and holidays) after admission. At the time of the review an expected length of stay for each patient shall be established based upon

the admitting diagnosis and the average length of stay applicable to like patients as prepared by the Hospital Utilization Project or the Professional Activity Study. If the Provider does not subscribe to either service, Blue Cross will provide similar data regarding length of stay to the Provider.

3.1.3. *Monitoring and Evaluation of Cases.* Following the initial review by the Utilization Review Committee, the Provider shall have all cases monitored on a continuing basis and shall evaluate all Subscriber cases at least one (1) working day prior to the date established pursuant to subsection 3.1.2 above, in order to establish the medical necessity of continued hospitalization.

(a) If further hospitalization beyond that period originally established is determined to be medically appropriate, the Utilization Review Committee shall establish a new expected length of stay consistent with its evaluation of the case. At the expiration of any expected stay, a new evaluation shall be made.

(b) If further hospitalization is not found to be medically appropriate, the Provider shall so advise the Subscriber and the attending physician, and give written notice to the Subscriber that he, and not Blue Cross, will be responsible for any expense incurred for hospitalization beyond the originally approved length of stay. The format of the notice to be so given shall have received the prior written approval of Blue Cross.

3.1.4. *Reporting Procedures.* Blue Cross shall furnish a quarterly report to the Provider listing the Provider's average length of stay for Subscribers according to the most frequent diagnoses in this general geographic area. If such report indicates that the Provider's experienced length of stay for any diagnosis is more than ten per cent

longer than the area average, the Utilization Review Committee shall determine the basis for this variance and submit a written explanation of the causes and suggested corrective measures to its governing body with a copy to RRC. All comparisons above shall be made with reference to data for patients under age 65.

3.1.5. *Additional Costs.* Any additional cost of the Utilization Review Program which Provider incurs as a direct result of an expansion, increase or modification of its existing services in order to satisfy the requirements set forth in subsections 3.1.2, 3.1.3 and 3.1.4 shall be a reimbursable cost hereunder and treated as a new service.

3.2. Advanced Utilization Review Program. Provider may elect in lieu of the Basic Utilization Review Program to establish and maintain an Advanced Utilization Review Program similar to the Quality Assurance Program ("QAP") of the American Hospital Association by delivering written notice of such election to Blue Cross.

3.2.1. *Implementation of Inpatient Program.* Commencing the date on or after July 1, 1976 that the Provider meets the standards of an Advanced Utilization Review Program approved by Blue Cross, with the right of the Provider to appeal Blue Cross' rejection pursuant to Section 20, and continuing so long as Provider maintains such program, Blue Cross shall provide developmental financing to Provider in the form of an unrestricted grant equal to $12.50 per inpatient service benefit Blue Cross paid case. These grants shall be paid monthly to the Provider by Blue Cross. Further, during such period, reimbursement shall not retrospectively be denied by Blue Cross for admissions reviewed pursuant to such program.

3.2.2. *Outpatient Utilization Review Program.* Blue Cross will make available, as provided below, unrestricted

developmental grants to a Provider which has in effect an Advanced Utilization Review Program, as of a date, on or after July 1, 1976, that the Provider implements an Outpatient Utilization Review Program approved by Blue Cross, with the right of the Provider to appeal Blue Cross' rejection pursuant to Section 20.

3.2.3. *Calculation of Grant Payments.* The grants provided by subsection 3.2.2 shall be paid monthly by Blue Cross to Provider, as appropriate and continuing so long as Provider maintains such program, on the basis of $2.50 per Emergency Room Blue Cross paid case and $6.25 per service benefit Blue Cross paid case that is handled in the Provider's Short Procedure Unit, as such is defined and certified for such payments pursuant to Section 25 hereof.

3.3. Maintenance of Records.

The Provider shall maintain detailed records of its activities described in this Section to permit comprehensive review by Blue Cross.

3.4. Provider Designated PSRO Status.

A Provider participating in a designated Professional Standards Review Organization program to the extent of (i) admission certification, (ii) continued stay review, and (iii) medical care evaluation studies may apply to the RRC for waiver of the requirements of subsections 3.1.2, 3.1.3 and 3.1.4.

Section 4. Calculation of Inpatient Days.

4.1. *Inpatient Day.* For purposes of this Agreement, an inpatient day begins at midnight and ends twenty-four hours later. The midnight-to-midnight method is to be used in reporting days of care for Subscribers, even if the Provider uses a different definition of inpatient day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. The day of discharge or a day on which a patient begins a leave of absence is not counted as a day, but this limitation does not apply to covered ancillary services on the day of discharge. If admission and discharge occur on the same day, such day is considered a day of admission and counts as one inpatient day.

4.2. *Late Discharge.* If a Subscriber continues to occupy his accommodations beyond the Provider's regular discharge hour, after being advised prior to such discharge hour that further hospitalization is not required, the Provider may charge the Subscriber for any unreimbursed charges applicable to such continued stay.

4.3. *Leave of Absence.* The day on which a Subscriber begins a leave of absence shall be treated as a day of discharge and not counted as an inpatient day unless he returns to the Provider by midnight of the same day. The day the Subscriber returns to Provider from a leave of absence is treated as a day of admission and counted as an inpatient day if he is physically present at midnight of such day.

4.4. *Limited Number of Days.* If the Subscription Agreement provides a limited number of days for certain surgical cases, the day on which the operation is performed is included in the days allowed the Subscriber under the Subscription Agreement.

Section 5. Accommodations.

Semi-private accommodations including routine general services, which term shall mean accommodations having two, three or four beds per room, are Covered Services for which the Provider shall be entitled to be

reimbursed as provided in this Agreement. A single occupancy room offered as a semi-private accommodation shall be considered a semi-private room for reimbursement purposes, provided the charge for such is the same as that for Provider's other semi-private accommodations. When accommodations other than semi-private are furnished, reimbursement for such will be adjusted in the following manner:

5.1. Private Rooms Medically Necessary.

5.1.1. Private rooms or other accommodations, including intensive care and other specialty service facilities more expensive than semi-private, will be Covered Services only when such accommodations are medically necessary. Such accommodations shall be considered medically necessary when the attending physician has noted on the Subscriber's medical chart that the Subscriber's condition requires that he be isolated for his own health or that of others.

5.1.2. Isolation may be necessary when treating certain communicable diseases in order to avoid cross-infection, as well as other physical and mental conditions when privacy is necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

5.2. Private Rooms Not Medically Necessary.

5.2.1. When accommodations more expensive than semi-private are furnished the Subscriber at the time of admission because less expensive accommodations are not available, Blue Cross will reimburse the Provider on the same basis as is applicable to semi-private accommodations.

5.2.2. When accommodations more expensive than semi-private are furnished the Subscriber at his request

and in the absence of medical appropriateness, the Provider may charge the Subscriber for the difference between the charges for the accommodations furnished and the credit for those accommodations included in Covered Services. No such charge may be made to the Subscriber unless he requested the more expensive accommodations with knowledge that he would be charged the differential.

5.3. Wards.

5.3.1. When ward accommodations, which term shall mean five or more beds per room, are furnished the Subscriber at his request, or when semi-private accommodations are not available at the time of his admission, reimbursement shall be made on the same basis as is applicable to semi-private accommodations; however, it is understood and agreed that the Subscriber must be moved to semi-private accommodations when they become available unless the Subscriber specifically requested ward accommodations at the time of his admission.

5.3.2. When ward accommodations are furnished neither at the Subscriber's request, nor due to the lack of available semi-private accommodations, the reimbursement for ward accommodations shall be on the same basis as is applicable to semi-private accommodations, minus a "ward differential" which shall be computed by calculating the difference between the Provider's customary charges for semi-private accommodations at its most prevalent rate in effect at the time of the Subscriber's admission (the rate which applies to the greatest number of semi-private beds) and the charge customarily made for the ward accommodation furnished the Subscriber.

5.3.3. When ward accommodations are furnished not at the Subscriber's request, or due to the lack of available semi-private accommodations, for a period exceeding three

days, the entire admission shall be considered a ward admission and all days charged for this admission shall be adjusted in the manner described in subsection 5.3.2 above. However, when ward accommodations are initially furnished because semi-private accommodations are unavailable and the Subscriber is subsequently moved to a semi-private accommodation within three days following the date of admission, the entire admission shall be considered semi-private.

5.4. Specialty Service Facilities. Reimbursement for the use of intensive care facilities and other specialty service facilities will be made in accordance with subsection 5.1 when such are medically necessary, except where explicitly excluded from Covered Services by the applicable Subscription Agreement.

Section 6. Provider Employees and Private-Duty Nursing.

The reasonable cost of Covered Services rendered by all personnel engaged by the Provider (either on a salary or fee-for-service basis), under arrangements which provide for billing to be made by the Provider, shall be included as a reimbursable cost hereunder.

The cost of private-duty nurses or private-duty attendants (registered professional nurses, licensed practical nurses, or any other trained attendants) whose services are rendered to and restricted to a particular Subscriber by arrangement between the Subscriber and the private-duty nurse or attendant is not reimbursable hereunder.

Section 7. Covered Services Obtained from Outside Sources.

In order to avoid unnecessary duplication of services, the Provider shall institute procedures whereby Covered

Exhibit C

Services, including timely tests and other diagnostic and therapeutic procedures, performed by outside sources such as pathologists, radiologists and other hospitals, which are licensed pursuant to applicable state regulation, meet the Provider's established quality standards and have been approved by the Provider, will be accepted for use in rendering patient care. Provider shall institute such procedures as may be required for the reasonable regulation of its medical staff directed toward the continued concentration of these tests within its facilities so as to prevent undue escalation of Provider's unit cost for such services. Except for those certain medical services incident to hospitalization provided for in Section 9 hereof, the Provider may not allow those furnishing Covered Services to bill Subscriber for such services.

Where Covered Services are obtained for Subscribers from outside sources, reimbursement hereunder shall be made on the same basis as though these services had been performed by the Provider. In those cases where the Provider has consolidated any of its ancillary services with those of another health care institution, reimbursement for the Covered Services performed there shall be on the same basis as if such services had been rendered through the Provider's own facilities.

Section 8. Physician Recommendations.

Covered Services shall be rendered to a Subscriber only upon the recommendation of a physician who is either a member of the medical staff or acceptable to the Provider and shall continue only during such period as the Subscriber is in need of hospital care for the treatment of illness or bodily injury and under the care of such a physician.

Exhibit C

Section 9. Arrangements Between Providers and Physicians.

9.1. *Reimbursement by Blue Cross.* The Provider and physicians rendering those certain medical services provided for herein may commence, continue, revise or terminate arrangements between them for those services as in their discretion they see fit. In determining reimbursement pursuant to Exhibit A, Blue Cross will recognize the applicable arrangements prevailing between the Provider and those physicians who render certain covered medical services when incident to the hospitalization of Subscribers as provided hereunder.

9.1.1. Under such arrangements when the bills for such covered medical services are included in the Provider's bills rendered to all patients, the compensation paid to physicians rendering those services shall be included as a part of the Provider's cost of those services. After the allocation of costs in accordance with subsection 2.3 of Exhibit A, Part I, the determination of cost of Covered Services to Blue Cross Subscribers shall be made in accordance with subsection 2.2 of Exhibit A, Part I.

Blue Cross will pay the Provider the cost of such covered medical services as determined above, thereby indemnifying the Subscriber against such bills, and in addition will pay to the Provider the amount otherwise payable to the Provider hereunder for the hospital services rendered by it.

9.1.2. Under such arrangements when the bills for such covered medical services are billed directly to all patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills.

Exhibit C

The Provider also may have incurred unreimbursed cost in providing facilities for the rendering of such covered medical services. After the allocation of these costs, if any, in accordance with subsection 2.3 of Exhibit A, Part I, the determination of the inpatient cost of Covered Services to Subscribers shall be made in accordance with subsection 2.2 of Exhibit A if the Provider has either: (a) complete information with respect to the regular charges for those certain medical services for both Subscribers and all other patients who receive the services; or (b) complete information with respect to regular charges of the Provider made in connection with the rendering of the certain medical services for both Subscribers and all other patients who receive these services. In the event the information required in (a) or (b) above is not available, the determination of inpatient cost of Covered Services to Subscribers shall be made as follows: (i) on total occasions of inpatient medical service or a statistical basis of allocation approved for such use under Title XVIII of Public Law 89-97 (hereinafter called "Medicare") apportioned between Subscribers and all other patients or, if this information is not complete, (ii) on total inpatient admissions apportioned between Subscribers and all other patients. Blue Cross will pay the Provider the cost of such covered medical services as determined above and in addition will pay Provider the amounts otherwise payable hereunder for the hospital services rendered by the Provider.

9.1.3. Under such arrangements when the bills for any one of the certain medical services incident to hospitalization are included in the Provider's bill rendered to some patients, and when bills for such medical services are billed directly to some patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it as are billed directly by such

Exhibit C

physicians, of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills. The Provider's cost of such medical services shall be subdivided into those applicable to services billed for by the Provider and those applicable to services billed for by the physician. The cost of covered medical services for each of these categories shall then be determined in accordance with the methods described in subsections 9.1.1 and 9.1.2 above, as appropriate. Blue Cross will pay the Provider its cost as so determined.

9.1.4. Under arrangements where the bills for certain medical services incident to hospitalization have been billed directly to patients by such physicians, the Provider may have incurred cost in providing the facilities for the rendering of such covered medical services in return for an agreed upon payment by the physician to the Provider. Payments received by the Provider under such an arrangement shall be treated as a reduction of the Provider's allowable cost to the extent of such cost.

9.1.5. In the event the Provider has elected to be reimbursed on a prospective rate basis in accordance with Part II of Exhibit A, the Provider agrees that: (a) the amounts payable directly to physicians by Blue Cross under subsections 9.1.2 and 9.1.3 shall be excluded from the determination of such gross prospective rate; (b) the amounts otherwise payable by Blue Cross to the Provider for costs the Provider may have incurred in providing facilities for rendering medical services pursuant to subsections 9.1.1, 9.1.2 and 9.1.3 shall be incorporated from the determination of such gross prospective rate and no additional payment will be made by either Blue Cross or the Subscriber; and (c) the payments received by the

Provider pursuant to subsection 9.1.4 shall be deducted in making the determination of such gross prospective rate otherwise payable to the Provider by Blue Cross. To ensure the gross prospective rate adequately reflects the costs to Provider of the various arrangements which it has with physicians rendering covered medical services, Provider shall notify Blue Cross of any modification or amendment to such arrangements, and in such event Blue Cross will make appropriate changes in the gross per diem rate.

9.2. *Reporting Requirements.* The Provider shall report annually to its governing board or a committee thereof the actual compensation paid by Provider to the anesthesiologists, pathologists and radiologists on its staff for services to the Provider's inpatients and outpatients.

Section 10. Cost Saving Programs.

Provider shall, to the extent practicable, actively participate on a continuing basis in the following Blue Cross programs or equivalent programs approved by Blue Cross which seek to encourage the effective use of Provider's inpatient facilities: (a) preadmission testing; (b) short procedure unit as described in Section 25, (c) home care service, and (d) discharge planning; and maintain records of its activity in these areas.

Section 11. Systems Analysis.

In order to provide a means whereby more efficient methods of operation may be developed and implemented, the Provider shall assign one or more administrative employees the responsibility for systems analysis.

Section 12. Patient Information.

A program will be continued or established which will supply all patients with information regarding Provider's

procedures and practices. The intent of the program will be to insure that patients are advised of the Provider's facilities, services and practices in a timely fashion. In this regard, a patient Bill of Rights may be developed for adoption by individual Providers after adaptation to their particular institutions.

Provider shall submit its procedures which comply with the foregoing to the RRC within thirty days following execution of this Agreement, a copy of the patient booklet (and any subsequent changes thereof) used by Provider to furnish the foregoing information, and the form of questionnaire which Provider will supply each patient at or before discharge requesting information as to care and treatment while hospitalized at Provider.

Section 13. Generic Equivalents.

13.1. If the Provider has on its staff a full-time pharmacist, it shall maintain a Drug Formulary Committee either of its own, or in cooperation with area hospitals, which will develop and implement a program designed to ensure that drugs are dispensed by generic rather than brand name when the less expensive generic equivalent is available. As part of this program, Provider will utilize prescription blanks which contain a printed legend authorizing the pharmacy filling the prescription to dispense, when available, generic equivalents for the brand name drugs prescribed.

13.2 In developing the drug formulary program, it is recognized that in certain situations, it may be necessary and prudent for the prescribing physician to designate a specific brand name drug due to compounding differences in the generic equivalent. To allow for these unusual situations the Provider may make suitable internal

arrangements, provided the physician requiring such brand name drugs makes an appropriate notation on the patient's medical chart or similar record of his request.

Section 14. Cooperation Between the Provider and Blue Cross.

The Provider and Blue Cross agree to cooperate fully with each other in administering the various provisions of this Agreement. To that end, Blue Cross shall promptly furnish Provider such information as is necessary to verify the payments made to it by Blue Cross. Blue Cross shall submit to the Provider upon request: (a) monthly financial statements; (b) annual balance sheet, as well as an income and surplus statement, both certified by independent accountants within thirty days after the receipt thereof from the accountants; and (c) copies of all transactions and financial operating data having a bearing on this Agreement. Similarly, Provider shall submit to Blue Cross all cost information regarding its operations which is necessary for the administration of this Agreement, and will permit Blue Cross to examine and audit all records, documents and financial and statistical data which may relate to reimbursable costs as determined herein.

Section 15. Purchasing Procedures.

Provider's governing board, or a committee thereof, shall review the practice and procedures of its purchasing officers and agents to insure that the "Prudent Buyer Concept", as defined in the current Medicare regulations, is employed when making purchases of equipment, supplies and services. The reports and statistical data used by the purchasing officers and agents shall be made available to Blue Cross for review.

Section 16. Safety Control Program.

In order to maintain a comprehensive program of loss control and prevention, the Provider shall establish or maintain, as applicable, a safety program based on the American Hospital Association's "Hospital Safety Manual" and incorporating the principles set forth in the attached Exhibit C.

Section 17. Public Disclosure.

Provider and Blue Cross mutually agree that the public at large has a significant and continuing interest in the development of an effective, cost-efficient medical service program which is responsive to consumer needs. To ensure that the public is advised of the plans, programs and undertakings of both the Provider and Blue Cross, each party agrees that during the term of this Agreement they shall individually make available information relating to costs, facilities, services available and other pertinent financial and statistical data with respect to their own operation, and continue appropriate measures to assure adequate consumer participation in their respective activities.

Section 18. Accreditation.

In order to encourage the Provider to satisfy recognized minimal standards in providing patient care, Provider agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association. In the event the Provider is not so accredited, Blue Cross shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving the Provider thirty (30) days prior written notice of such intent to terminate.

Section 19. Areawide Planning of Health Care Facilities.

19.0. *Designation of Planning Agency.* The Agency which will perform the various planning and evaluation functions pursuant to this Section 19 shall, effective July 1, 1976, be the Regional Comprehensive Health Planning Council, Inc. (RCHP) which has signified its consent to do so by executing a master agreement defining its duties, obligations and responsibilities in this area. At such time as: (1) the performance by RCHP of those functions described in this Section 19 are recognized by the Federal Government pursuant to federal law as being able to be adequately performed by, and are reassigned to, a Health System Agency (HSA) or other federally designated agency (Successor Agency) operating in the county in which the Provider is located, and (2) the Successor Agency agrees to undertake the performance of all or any portion of those functions described in subsections 19.1, 19.2, 19.3 and 19.5, these functions shall be reassigned to the Successor Agency.

In the event that upon application by either Blue Cross or the Provider it is determined by mutual agreement or an arbitrator assigned from the Appeals Panel, described in Section 20, that any of the functions required to be performed by the Agency are no longer being performed, the performance of any such function shall be reassigned to the Reimbursement Review Committee (RRC), described in Section 24, which shall then retain a staff, or contract assistance, as the RRC deems necessary to assist it in the performance of such function. In the event the RRC is unable to reach a majority decision as to any matter referred to it for performance hereunder, the RRC will be joined by a member of the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. Subsequent to any assignment of function to the RRC, upon the application

of Blue Cross or Provider, the function or functions shall be reassigned to the RCHP, HSA or Successor Agency upon determination by the RRC that such proposed assignee agency is willing and prepared to perform the function sought to be reassigned. Whenever the RRC is performing a function under this Section 19, it shall be considered an Agency for purpose of this Section 19.

19.1. *Major Construction of Facilities.* If the Provider undertakes any project for the replacement or expansion of its facilities and equipment at an estimated cost in excess of $100,000 it will submit such project to the Agency for review prior to the letting of contracts therefor.

19.2. *Expansion of Certain Services.* If the Provider undertakes a project to provide either a new service listed below or expand an existing service listed below in such a way as to require in any one fiscal year additional space (beyond that theretofore used for such service) greater than 10% of the space theretofore so used, it will submit such project to the Agency prior to the letting of contracts therefor. The services referred to in this subsection are the following: (a) megavoltage radiation services; (b) open-heart surgery services; (c) obstetrical services; (d) pediatric services; (e) operating room services; (f) emergency care service; (g) diagnostic radiological services; (h) hemo-dialysis services; and (i) burn treatment services.

19.3. *Change of Function.* In addition to the requirements set forth in subsections 19.1 and 19.2, if the Provider has obtained the prior endorsement of the Agency for a given facility and desires within three years of such endorsement to change the function of the facility, or a substantial portion thereof, it shall submit and obtain the

endorsement of the Agency for such change prior to the implementation thereof.

19.4. *Denial of Reimbursement.* If the Agency refuses to endorse a project reviewed by it pursuant to subsection 19.1, 19.2 and 19.3 and the Provider, nevertheless, carries out the project, Blue Cross reimbursement to the Provider will be calculated without any allowance for the depreciation or interest expense with respect to the facilities of such project or the costs of services supplied by such project.

19.5. *Periodic Evaluation.* The Provider shall permit the Agency, during the term of this Agreement, to evaluate once every three years the need for the existing facilities of, and services supplied by, the Provider. The evaluation shall include a review of all facilities to determine if such conform to the then current requirements for new construction in respects which render them unsafe for patients. If the report of the Agency submitted to Blue Cross and the Provider recommends that a facility or service of Provider is no longer needed, it shall specify a reasonable time period by the end of which the facility or service, must be eliminated. Similarly, if the report states that a facility is unsafe, it shall specify a reasonable time period by the end of which the facility must be made safe or eliminated. After the end of a period so specified, Blue Cross reimbursement to the Provider shall be calculated without any allowance for the cost of facilities or services not eliminated or made safe in accordance with such evaluation, unless Provider is expressly prohibited from eliminating such facilities or services by law.

The Periodic Evaluation function required by this Section 19.5 may be accomplished by the Agency utilizing procedures mandated by federal law, as implemented by federal regulations and applicable state legislation, in lieu

of the procedure herein specified, provided that it is determined upon the application of Provider or Blue Cross by the RRC that such alternative procedures provide an equivalent evaluation function.

19.5.1. *Appeals.* In the event the Provider or Blue Cross does not agree with the decision of the Agency in connection with any function performed by the Agency other than that performed pursuant to the mandate of federal law as implemented by federal regulations and applicable state legislation, the Provider or Blue Cross may appeal such decision to an arbitrator assigned from the Appeals Panel, except that no appeal shall be permitted from a decision of the RRC in which an arbitrator has participated. Any decision by the Agency as to functions performed pursuant to the mandate of federal law, as implemented by federal regulations and applicable state law, shall be final and binding upon Provider and Blue Cross except to the extent appeals are available pursuant to such federal or state regulations and law.

19.6. *Financing.* Provider agrees to pay the cost of the work performed by the Agency pursuant to this Section 19 which is not provided to the Agency by other sources (including governmental funding) and Blue Cross agrees that this expense shall be included in the Provider's total allowable cost in the amount incurred for each fiscal year, or part thereof. The method of payment and calculation of cost shall be as described in the master agreement with the Agency or as prescribed by the RRC.

19.6.1. *Reimbursement by Blue Cross.* In calculating Blue Cross reimbursement, the Provider shall include its share of the total cost of the services to be performed by the Reviewing Agency pursuant to this Section 19 in its administrative cost using an approved method of cost finding in accordance with subsection 2.3 of Exhibit A,

Part I, and allocated in accordance with the approved method pursuant to subsection 2.2 of Exhibit A, Part I. In recognition of the potential benefits to be derived from this program in the containment of health care costs which will inure to subscribers, as well as to the community at large, Blue Cross agrees to assist the Provider in recovering that portion of this cost applicable to non-paying patients as follows:

Blue Cross shall make an unrestricted grant annually at the time of final settlement, separate and part from any other reimbursement required by this Agreement, in an amount equal to 100% of that portion of the Provider's cost attributable to the planning function performed by the Agency pursuant to this Section 19 which is applicable to the free care losses, excluding courtesy discounts ("free work"), for which no reimbursement would otherwise be received. The calculation of the amount of this grant shall be made in the following manner:

> Calculate the percentage that the free work charges are to the total gross charges for the fiscal year and then multiply the Agency's expense attributable to this Section 19 by that percentage. The resulting sum would then be attributable to free work, which expense will be reimbursed by Blue Cross in addition to that portion calculated to be payable by the Ratio of Charges to Charges Applied to Cost (R.C.C.A.C.) apportionment (this is a method of apportionment of each revenue producing department's cost on the basis of the ratio of Subscriber's Covered Services charges to total patient charges applicable to costs) of Blue Cross liability for Covered Services rendered to Subscribers.

The amount of this unrestricted grant is not to be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.4 of Exhibit A, Part I.

19.7. *Availability of Documents.* The Provider and Blue Cross shall make available to the Agency and its staff such documents, cost projections, prior planning agency reports and worksheets, files and other pertinent material as the Agency may reasonably request in order to accomplish the reviews described in this Section 19.

19.8. *Prior Planning Agency Determinations.* Determinations made by the designated Planning Agency pursuant to Section 24 of the 1971 Hospital Agreement, as modified by the 1973 Summary of Principles, prior to June 30, 1974, shall continue in full force and effect, but:

> (a) Any determination made after that date, but prior to July 1, 1976, shall not be used by Blue Cross as the basis for denying or reducing a Provider's reimbursement after the effective date of this Agreement; and
>
> (b) Either Blue Cross or the Provider may request a redetermination by the Agency designated pursuant to Section 19 of any determination made during the period July 1, 1974 to June 30, 1976, inclusive which requires future affirmative action by the Provider.

The RRC shall determine if this subsection applies to any Provider or set of circumstances upon appropriate application by Blue Cross or the Provider.

Section 20. Right of Appeal.

20.1. Appeals Panel.

Any disagreement between the parties hereto concerning this Agreement or its application, operation or interpretation, [except as to decisions made by the RRC which shall be final, binding and nonappealable], shall be referred to a disinterested arbitrator assigned by the RRC

from a list of arbitrators jointly selected by counsel for Blue Cross and the Delaware Valley Hospital Council (DVHC) on behalf of the Providers contracting hereunder prior to the date this Agreement is approved by the Pennsylvania Insurance Department. Subsequent additions or deletions from this list will be made only upon unanimous approval of the RRC. Assignment of the arbitrator by the RRC shall be made seriatim from the list in accordance with the sequence established by counsel at the time the list is initially presented to the RRC.

20.2. Procedure.

The arbitrator assigned to hear any matter shall conduct a formal hearing in conformance with the rules and regulations applicable to Commercial Arbitration as published by the Amercian Arbitration Association. Within thirty days following the conclusion of the hearing, the arbitrator shall forward his adjudication to the Provider and Blue Cross. The adjudication shall be in writing and signed by the arbitrator, and shall be final, binding and nonappealable.

20.3. Appeal Process Exclusive.

The appeal procedure described herein is the exclusive means for determining all disputes and disagreements as to this Agreement and its application, operation or interpretation, and no action at law or in equity shall be maintainable by either party to this Agreement against the other with respect to this Agreement, its application, operation or interpretation. Further, no appeal under this Section shall be maintainable unless brought within 2 years of the date the cause of action first arose. An appeal shall be deemed commenced when written notice of an appeal is delivered to the RRC and the other party hereto.

20.4. Costs of Appeal.

The costs associated with the foregoing appeals procedure shall be borne equally by the parties thereto and the Provider's share of such costs shall be included as a reimbursable cost hereunder.

Section 21. Term of Agreement.

21.1. This Agreement shall commence on July 1, 1976 and expire on June 30, 1978, provided however, that if Act 94 of 1975 is no longer applicable to the termination of this Agreement it shall be automatically extended through June 30, 1979. This Agreement shall supersede all previous agreements between the parties hereto, although it is expressly agreed that the 1971 Hospital Agreement (exclusive of subsection 18.4.6 therein and the 1972 amendment thereto), as modified by the 1973 Summary of Principles agreement between the parties hereto, shall apply to all admissions during the period July 1, 1974 to June 30, 1976, inclusive, and during the term of this Agreement, no limitations on total allowable costs as expressed in superseded agreements shall be applied for fiscal years commencing on or after July 1, 1974.

21.2. In making final settlement for fiscal years 1975 and 1976, all indemnity payments made by Blue Cross to Subscribers on account of Covered Services furnished by the Provider during the period the Provider was a "Nonmember Hospital," as defined in their respective Subscription Agreements shall be deducted from allowable cost hereunder. Each payment made by a Subscriber to the Provider during this period which was in excess of cost shall be retained by Provider and shall not be applied by Blue Cross to reduce reimbursement hereunder.

21.3. In the event this Agreement terminates as provided heretofore, any depreciation allowed as a result of a subsequent contract between Blue Cross and the Provider shall be calculated using the asset basis and method required by Exhibit A, Part I.

Section 22. Obligations After Termination.

In the event this Agreement terminates for any of the reasons set forth herein the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and who were inpatients on the date of such termination.

Section 23. Medical Staff Privileges.

The Provider agrees to maintain the standards for staff appointment established by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Section 24. Budgetary Review Procedures.

24.1. *Reimbursement Review Committee.* To ensure that the reimbursement hereunder is established in a fair and equitable manner, a Reimbursement Review Committee (hereinafter called "RRC"), shall be formed to review the submitted budgets and subsequent reports of all contracting Providers and shall establish interim rates thereof. The RRC will be responsible for review, interpretation and application of any Principles set forth in Exhibit A Principles of Reimbursement as requested by either Provider or Blue Cross. The RRC shall consist of four members and a quorum of four members or their alternates is required for any action. The Delaware Valley

Hospital Council (DVHC) and Blue Cross shall each appoint two regular members and such voting alternates as the DVHC and Blue Cross may from time to time designate. All actions of the RRC shall require an affirmative vote of three to pass. Notice of all matters to be considered at any meeting of the RRC must be provided at least three business days prior unless waived by the RRC membership. Further, the RRC may adopt such rules and procedures as it shall determine are necessary to carry out its duties and responsibilities hereto.

24.2. *Submission and Review of Budget.* Each Provider shall submit its annual budget to the RRC not later than the May 15th prior to the beginning of each fiscal year on the standard form attached hereto as Exhibit B, which may from time to time be modified by the RRC as prescribed by the RRC. The budget as submitted shall have the prior approval of the Provider's governing board or its financial committee charged with the responsibility of preparing such material. The budget shall also contain an explanation of any unusual factors affecting the Provider's cost, such as, but not limited to, changes in patient mix, volume and new or reduced services. The RRC shall review the data submitted by Provider in accordance with the provisions of Exhibit A utilizing the following procedures:

24.2.1. If the RRC shall determine that the budget is reasonable and correct, it shall so advise the Provider and Blue Cross utilizing the gross inpatient per diem rate proposed by the Provider in its budget as the basis for interim reimbursement for patient days during such budgeted fiscal year.

24.2.2. If the RRC questions the reasonableness of the interim rate proposed in the budget, the RRC shall, within 30 days of receipt of the budget, so advise Pro-

vider and request additional data and a meeting with the Provider's representatives, as indicated. The RRC shall promptly forward a report of the interim rates it has found reasonable to Blue Cross.

24.2.3. If the RRC is unable to reach a majority decision as to the interim rate, it shall be joined by an arbitrator from the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. In the event of any such disagreement, and until a final decision is rendered, the interim rate to be paid by Blue Cross shall be the rate indicated in the submitted budget, unless the Provider advises Blue Cross it desires a lower rate be used for interim reimbursement. Following entry of a decision, the interim rate will be adjusted retroactively and any overpayment or underpayment, together with interest thereon at an annualized rate of one and one quarter percent above the prime commercial rate charged by the Philadelphia National Bank during such period, shall be paid or refunded by Blue Cross or Provider as appropriate.

24.3. Adjustments to Interim Rate.

24.3.1. The interim rate established by the RRC shall be subject to review and adjustment upon application of the Provider or Blue Cross. Changes in the interim rate may thereafter be applied retroactively by the RRC.

24.3.2. Provider shall submit quarterly to the RRC its statement of current operating costs within seven working days following the date when such is reviewed by its governing board or financial committee. The statement as submitted to the RRC shall show the actual operating expense of the Provider with budget comparisons for such period.

24.3.3. When the gross inpatient interim per diem rate has been established utilizing unaudited data, such rate shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustment, excluding nonrecurring items, amounts in aggregate to more than $1.00 per patient day.

24.4. *RRC Costs.* The operational costs of the RRC, except those applicable to Section 19 hereof, shall be borne equally by Blue Cross and those Providers contracting with Blue Cross under agreements which include provisions for a RRC. Further, those Providers shall pay the salaries and expenses of their designated representatives on the RRC, as well as any other compensation or benefits furnished such individuals, which costs will be recognized as a reimbursable cost hereunder. Similarly, Blue Cross will pay the costs associated with the salaries and expenses of its representatives on the RRC.

24.5. *Prospective Rating.* Provider may elect in lieu of reimbursement otherwise payable by Blue Cross under this Agreement to negotiate a fixed gross inpatient per diem rate or an aggregate annual rate of reimbursement (herein the "Prospective Rate") which shall be payable by Blue Cross in appropriate increments no less frequently than semi-monthly. Any Prospective Rate shall be determined to the mutual satisfaction of the parties based upon the Provider's approved budget. If during the prospective year there is a change in the arrangements described in Section 9 hereof, an appropriate concurrent change in the Prospective Rate shall be made. Moreover, it is agreed that such rate shall not be subject to review or appeal pursuant to Section 20 hereof. And the Provider will be permitted to retain for improvement of services all overage received by achieving a cost which

is below the Prospective Rate or be required to absorb any deficiency if during the appropriate final period its cost should exceed payments received under the negotiated Prospective Rate. Any grants, other than mere reimbursement or expenses incurred, to be paid Provider by Blue Cross pursuant to this Agreement shall be separate and apart from the amounts to be paid pursuant to this Subsection 24.5.

24.6. Additional RRC Responsibilities.

24.6.1. The RRC shall establish guidelines which Blue Cross shall utilize in approving all applications seeking the establishment of a Provider Outpatient Utilization Review Program which would qualify for grant payments by Blue Cross.

24.6.2. The RRC shall review the guidelines for Short Procedure Units which are contained in Section 25 and may from time to time recommend changes to those guidelines.

24.6.3. The RRC will undertake the various areawide planning functions described in Section 19 hereof.

Section 25. Short Procedure Units.

The Provider may apply to Blue Cross at any time during the term of this Agreement for certification of a Short Procedure Unit ("SPU"). In the event an SPU is so certified, reimbursement shall be made on the basis of reasonable cost. Routine service charges in the SPU may not exceed the Provider's daily service charge for the most prevalent semi-private accommodations for one day.

25.1. *Certification as a Short Procedure Unit.* The guidelines which shall be utilized in determining if Provider's SPU may be certified by the Plan are:

25.1.1. The Short Procedure Unit must be an identifiable function established by the Provider for the performance of therapeutic and diagnostic procedures that (i) cannot safely or appropriately be accomplished on a conventional outpatient basis, (ii) are best done in a hospital setting, and (iii) are usually completed within an eight-hour period without requiring an overnight stay in the hospital. Exceptions to the foregoing eight-hour limit may be made when justified.

25.1.2. The procedures to be performed in the SPU are usually those that can be scheduled in advance by the attending physician, but after which the patient cannot be discharged without a limited period of post-procedure observation.

The SPU will maintain a list of approved therapeutic and diagnostic procedures to be performed in the SPU. This list is open to permit additional procedures to be added as the need is identified. Some examples of the procedures which are customarily performed in the SPU and would be approved for reimbursement by Blue Cross are:

Certain multiple x-ray studies

Endoscopic procedures

D&C's and D&E's

Transfusions

Certain chemotherapeutic procedures

Angiograms

A wide range of minor surgical procedures, especially those requiring general anesthesia and observation of the patient for a period of time following the procedure.

25.1.3. The volume of procedures necessary to justify an SPU should require a minimum of four-designated

beds for post-procedure recovery (which may be used for other purposes in the event of insufficient SPU procedures) and appropriate staffing.

25.1.4. The SPU should include professional and administrative control and supervision to assure appropriate utilization so that patients are not admitted who could be appropriately cared for on a conventional outpatient basis.

25.2. Subscriber Benefits.

Blue Cross will provide benefits to Subscribers for approved procedures in a certified SPU as if they were inpatients.

25.3. Medical Staff and Patient Information.

Appropriate material shall be developed by the Provider for the information of its medical staff concerning utilization and scheduling as well as brochures for distribution to patients who will be cared for in the unit.

25.4. Review.

The RRC shall from time to time review the utilization review standards and qualifications for certification that an SPU shall satisfy as a prerequisite to continued grant payments pursuant to Section 3.

Section 26. Use of Modern Management Techniques.

26.1. The Provider may during the term of this Agreement undertake a comprehensive study of its operating or administrative procedures utilizing one or more independent consulting agencies to assure an optimal organization structure and fix staffing levels for each of its departments, using objectives acceptable to both the Provider and Blue Cross. Further, it is agreed that any such study may be undertaken with other hospitals on a

joint basis, and if the Provider has commenced or is continuing any such study, said study will satisfy the terms of this Section for the periods subsequent to July 1, 1976 if it has received the approval of Blue Cross. The cost of any such study shall be included in the operating costs of the Provider which are reimbursable in accordance with this Agreement for the applicable fiscal year in which payments are made.

26.2. If the study described in subsection 26.1 above is initiated by Provider, or other general or special management studies are undertaken which are determined by Blue Cross to be consistent with this Agreement, and if initial implementation of the recommendations produced by such study is commenced within six months immediately following the date of such recommendations, Blue Cross will make an unrestricted grant separate and apart from any other reimbursement required by this Agreement, based on the total cost of such study up to $100 per bed annually ($300 per bed annually in the case of general management studies). The foregoing grant shall be in a sum equal to the amount obtained by determining the maximum allowable per diem cost of the study applicable to all inpatient days during such fiscal year which have been provided to other than free and part-pay patients and multiplying such allowable per diem cost by the number of Blue Cross inpatient days provided during the applicable fiscal period.

26.3. In order to ensure that the recommendations of the foregoing studies are available for use by other health care institutions seeking to develop cost-saving programs, the Provider shall furnish to Blue Cross and the RRC on a scheduled basis a summary of all reports and relevant data regarding the results and implementation of its studies so that such information may be periodically distributed to other area hospitals.

Section 27. Section Headings.

The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

IN WITNESS WHEREOF, the parties hereto have caused these presents to be executed by their proper officers as of the date of execution set forth below.

Date of
Execution

_____ _____
Name of Provider

Effective Date

_____ By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER
PHILADELPHIA

_____
President

EXHIBIT A

PRINCIPLES OF REIMBURSEMENT

For purposes of establishing the amounts to be paid Provider by Blue Cross pursuant to this Agreement, Provider shall have the option during the term of this Agreement of being reimbursed on the basis of either "Reasonable Cost" or a "Prospective Rate", as such are more fully described hereinafter. The Provider must advise Blue Cross in writing which method it has elected prior to the end of the second month of each prospective fiscal year. This election once made by Provider may not be changed for such fiscal year. In the event Provider fails to make an election within the prescribed period, or is unable to reach agreement with Blue Cross on a Prospective Rate, the reimbursement to be paid Provider shall be calculated on the basis of "Reasonable Cost" as described in Part I of this Exhibit A.

PART I. REASONABLE COST BASIS

It is the intention of the parties hereto that application of the Principles set forth in Sections 1 and 2 hereof shall be made utilizing all current and future applicable Medicare interpretations, instructions and manuals containing informational and procedural matter as regards the various determinations of cost under these Principles, as promulgated by the Social Security Administration, Bureau of Health Insurance, or their successors, except where the Principles would make such material inappropriate.

No amendment to the Medicare Law, nor change in the sections of the Medicare Regulations captioned "Principle", as promulgated on July 1, 1967 shall be applicable to this Agreement.

Exhibit C

Section 1. PRINCIPLES TO BE USED IN DETERMINING SPECIFIC REIMBURSABLE COSTS.

1.1. Allowance for Depreciation Based on Asset Costs. (Sec. 405.415)

Principle

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation to be allowed under this Agreement must be:

(a) Identifiable and recorded in the Provider's accounting records from the date of acquisition, or appraisal if not recorded upon acquisition;

(b) Based on the historical cost of the asset (including assets financed with Hill-Burton or other federal or public funds) or fair market value at the time of donation in the case of donated assets; and

(c) Prorated over the remaining estimated useful life of the asset as in use as of July 1, 1971, using the straight-line method and based on the remaining undepreciated value, if any, as of July 1, 1971, with respect to depreciation taken for Blue Cross purposes under previous contracts between the Provider and Blue Cross.

1.1.1. Definitions.

(a) "Historical cost" is the cost incurred by the present owner in acquiring the asset.

(b) "Fair market value" is the price which the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Exhibit C

(c) Under the straight-line method of depreciation the cost or other basis (e.g. fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is first determined. This sum is then distributed equally over the estimated useful life of the asset.

1.1.2. Recording of Depreciation.

Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, historical cost, estimated useful life, and accumulated depreciation for Blue Cross purposes. The "Chart of Accounts" published by the American Hospital Association shall be employed as a guide in determining the estimated useful lives of assets.

1.1.3. Funding of Depreciation.

Although funding of depreciation is not required, it is strongly recommended that Providers use this mechanism as a means of conserving funds for replacement of depreciable assets. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

1.1.4. Gains and Losses on the Disposal of Depreciable Assets.

Gains and losses realized from the disposal of depreciable assets are to be included when computing allowable costs. If the gains or losses on the disposal of depreciable assets in a given fiscal year are greater than 10% of the total allowable depreciation for that period, the amount of gain or loss in excess of 10% must be carried forward over the next five succeeding years. Proper books of account identifying the gain or loss carry-forward for each

individual year must be separately maintained by Provider and any such carry-forward shall be considered first in determining the 10% limitation for any year.

The amount of gains and losses which are includable in allowable costs shall be calculated as follows:

(a) When an asset which was acquired by Provider before the date it entered into a "cost-type contract" with Blue Cross (hereinafter called the "Entry Date") is disposed of, a correction of prior years' depreciation based on actual life must be made before determining any gain or loss. The depreciation accumulated before the Entry Date must be corrected in the same manner as when making a new estimate of the asset's useful life. The gain or loss is the difference between the amount received for the asset and the corrected undepreciated cost at time of sale.

(b) Gain or loss on the disposal of assets acquired after the Entry Date is the difference between the sale price of the asset and the asset's unrecovered cost.

1.1.5. Establishment of Cost Basis on Purchase of Facility as Ongoing Operation.

In establishing the cost basis for a facility purchased as an ongoing operation after July 1, 1971, the price paid by the purchaser shall be the cost basis where it can be demonstrated that the transaction was a bona fide sale and the price paid did not exceed the fair market value of the facility at the time of sale. If a transaction is demonstrated to be other than a bona fide sale, the cost basis for depreciation purposes pursuant to this Agreement shall not exceed the undepreciated value calculated for Blue Cross purposes of such assets at the time of sale.

1.2. Interest Expense. (Sec. 405.419)

Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

1.2.1. Definitions.

(a) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term which is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(b) Necessary requires that the interest be:

(i) incurred on a loan made to satisfy a financial need of the Provider as loans which result in excess funds or investments shall not be considered necessary;

(ii) incurred on a loan for a purpose reasonably related to patient care; and,

(iii) reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from the Provider's qualified pension fund or funded depreciation shall not be used to reduce interest expense.

(c) Proper requires that interest be:

(i) incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made; or

(ii) paid to a lender not related through control, ownership or personal relationship to the borrowing organization; however, interest is allowable if paid on loans from the Provider's donor-restricted funds, funded depreciation account or qualified pension fund.

1.2.2. Borrower-Lender Relationship.

(a) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan and thus be suggestive of an agreement on higher rates, interest or unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the Provider to related organizations is not allowable.

(b) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to the Provider by related organizations made prior to July 1, 1966 is an allowable cost, provided, the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a Provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the Provider's qualified pension fund, funded depreciation account, or funds borrowed

from the religious order responsible for the operation of the Provider.

(c) Where funded depreciation is used for purposes other than improvement replacement or expansion of facilities or equipment related to patient care, the allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in Provider's qualified pension fund when such are used for purposes other than that for which the fund was established.

(d) The allowable interest expense on the current indebtedness of the Provider will be adjusted to reflect the extent to which working capital needs attributable to Covered Services for Subscribers have been met by Blue Cross payments designed to provide reimbursement for services currently furnished to Subscribers. Any interest paid by the Provider to Blue Cross pursuant to subsection 24.2.3 of this Agreement shall not be a reimbursable cost hereunder.

1.3. Bad Debts, Charity, and Courtesy Allowances. (Sec. 405.420)

Principle

Bad debts, charity and courtesy allowances are deductions from revenue which are not to be included in allowable cost; however, bad debts attributable to Subscriber deductibles and coinsurance amounts are reimbursable hereunder.

1.3.1. Definitions.

(a) "Bad debts" are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing Covered Services. "Accounts receivable" and "notes receivable" are designations

for claims arising from the rendering of services and are collectible in money in the relatively near future.

(b) "Charity allowances" are reductions in charges made by the Provider because of the indigence or medical indigence of the patient.

(c) "Courtesy allowances" are reductions in charges in the form of an allowance to physicians, clergy, members of religious orders and others as approved by the governing body of the Provider for services received from the Provider. Employee fringe benefits, such as hospitalization and personal health programs, are not considered to be courtesy allowances.

1.3.2. Normal Accounting Treatment, Reduction in Revenue.

Bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing services. Such costs have already been incurred in the production of the services.

1.3.3. Requirements of this Agreement.

Under this Agreement the cost of Covered Services furnished Subscribers is not to be borne by individuals not covered by Blue Cross, and conversely, the cost of services provided for other than Subscribers is not to be borne by Blue Cross. Uncollected revenue related to services rendered to Subscribers generally means the Provider has not recovered the cost of services covered by that revenue. The failure of Subscribers to pay the deductible and coinsurance amounts can result in the related costs of Covered Services being borne by other than Subscribers. The costs attributable to deductibles and coinsurance amounts, which remain unpaid, are to be added to the Blue Cross share of allowable costs. Bad debts arising from other sources are not allowable costs.

1.3.4. Criteria for Allowable Bad Debts.

A bad debt must meet the following criteria to be allowable:

(a) The debt must be related to Covered Services and derived from deductible and coinsurance amounts;

(b) The Provider must be able to establish that reasonable collection efforts were made;

(c) The debt was actually uncollectible when claimed as worthless; and

(d) Sound business judgment established that there was no likelihood of a future recovery.

1.3.5. Charging of Bad Debts and Bad Debt Recoveries.

The amounts uncollectible from specific Subscribers are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to Blue Cross may be recovered in a subsequent accounting period, in which event the income therefrom must be used to reduce the cost of Subscriber Covered Services for the period in which the collection is made.

1.3.6. Charity Allowances.

Charity allowances have no relationship to Subscribers and are not allowable costs. The cost to the Provider of employee fringe-benefit programs is an allowable element of reimbursement.

1.4. Cost of Educational Activities. (Sec. 405.421)

Principle

An appropriate part of the net cost of approved educational activities is an allowable cost.

1.4.1. Definitions.

(a) Approved educational activities mean formally organized or planned programs of study usually engaged in by the Provider in order to enhance the quality of patient care at an institution. These activities must be licensed where required by state law. Where licensing is not required, the institution must receive approval from the recognized national or state professional organizations for the particular activity.

(b) Net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers and other costs) less any reimbursement from grants, tuition, fellowships and other specific donations.

(c) Appropriate part means the net cost of the approved activity apportioned in accordance with the method set forth in this Exhibit A, Part I.

1.4.2. Educational Activities.

Many Providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community, however, many communities have not assumed responsibility for financing

these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, Blue Cross will participate appropriately in the support of these activities. Although the intent of Blue Cross is to share in the support of educational activities customarily or traditionally carried on by Providers in conjunction with their operations, it is not intended that Blue Cross should participate in increased costs resulting from distribution, transfer or redistribution of costs from educational institutions or units.

1.4.3. "Orientation" and "On-the-Job Training."

The cost of orientation and on-the-job training are not within the scope of this subsection but are recognized as normal operating costs in accordance with the subsections relating thereto.

1.4.4. Approved Programs.

In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by Provider institutions, and their approving bodies, include the following:

Program	*Approving Organization*
(a) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(b) Dietetic interships	The American Dietetic Association.

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Program	*Approving Organization*
(c) Hospital administration residencies	Members of the Association of University Programs in Hospital Administration.
(d) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(e) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(f) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(g) Nurse anesthetists	The American Association of Nurse Anesthetists.
(h) Professional nursing	Approved by the respective state authorities; reported for the United States by the National League for Nursing.
(i) Practical nursing	Approved by the respective state authorities; reported for the United States by the National League for Nursing.

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(j) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(k) Pharmacy residencies	American Society of Hospital Pharmacists.
(l) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(m) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

1.4.5. Other Educational Programs.

There may also be other educational programs not included in the foregoing in which the Provider is engaged. Appropriate consideration will be given by Blue Cross to the costs incurred for those activities that come within the purview of this subsection when determining allowable costs for apportionment under this Agreement.

1.5. Research Costs. (Sec. 405.422)

Principle

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual

patient care and are not otherwise reimbursed, shall be excluded from allowable cost.

Application

(a) There are numerous sources of financing for health-related activities. Funds for this purpose are provided under many federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs.

(b) To ensure that all identifiable costs associated either directly or indirectly with research are not included in computing reimbursable cost, Provider shall maintain detailed books of account and other records as are necessary to identify research costs.

(c) Normal and usual costs of patient care which are not reimbursed from other sources shall be included as an allowable cost when incurred directly or indirectly for research purposes.

1.6. Grants, Gifts and Income from Endowments. (Sec. 405.423)

Principle

Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

1.6.1. Definitions.

(a) Unrestricted grants, gifts and income from endowments are funds, cash or otherwise, given to the Provider without restriction by the donor as to their use.

(b) Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise which must be used only for specific purposes designated by the donor, but does not refer to unrestricted grants, gifts or income from endowments which have been restricted for a specific purpose by the Provider.

1.6.2. Application.

(a) Unrestricted funds, cash or otherwise, are generally the property of the Provider to be used in any reasonable manner its management deems appropriate and should not be deducted from operating costs.

(b) Donor-restricted funds which are designated for paying certain operating expenses of the Provider should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the Provider would secure reimbursement for the same expense twice being reimbursed through donor-restricted contributions as well as from patient and third-party payers including Blue Cross.

1.7. Value of Services of Nonpaid Workers. (Sec. 405.424)

Principle

The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and the

Provider for the performance of such services without direct remuneration from the Provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in this subsection. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses and paid no later than the end of the Provider's fiscal year following the fiscal year during which the services were rendered.

1.7.1. Limitations; Services of Nonpaid Workers.

To be reimbursable, the services of nonpaid workers must be performed on a regularly scheduled basis in positions customarily held by full-time employees and be necessary to enable the Provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which Providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under this Agreement. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a Provider canteen, cafeteria or gift shop, would not be reimbursable.

1.7.2. Application.

The following illustrates how the Provider would determine an amount to be allowed under this subsection. The prevailing salary for a lay nurse working in hospital A is $12,000 a year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $5,000 and are included in the hospital's allowable operating costs. The hospital would then include in its

records an additional $7,000 to bring the value of the services rendered to $12,000. The amount of $7,000 would be allowable where the Provider assumes the obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by Provider for the services.

1.8. Purchase Discounts, Allowances and Refunds of Expenses. (Sec. 405.425)

Principle

Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

1.8.1. Definitions.

(a) Discounts are generally reductions granted for the settlement of debts.

(b) Allowances are deductions granted for damage, delay, shortage, imperfection or other causes, excluding discounts and returns.

(c) Refunds are amounts paid back or a credit allowed on account of an overcollection.

1.8.2. Normal Accounting Treatment: Reduction of Costs.

All discounts, allowances and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchase was made or expense incurred, they will reduce the cost of the purchase or expense of that period. However, when they are received in a later accounting period they will reduce the cost of a comparable purchases or expenses in the period in which they are received.

1.8.3. Application.

(a) Purchase discounts have been classified as cash, trade or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(b) As with discounts, allowances and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in cost and must be reflected in the determination of allowable costs. This treatment is equitable and in accord with that generally followed by governmental programs and other third-party organizations paying on the basis of cost.

1.9. Cost of Related Organizations. (Sec. 405.427)

Principle

Costs applicable to services, facilities and supplies furnished to the Provider by organizations related to the Provider by common ownership or control are includable in the allowable cost of the Provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere.

1.9.1. Definitions.

(a) Related to the Provider means that the Provider to a significant extent is associated or affiliated with, has

control of, or is controlled by the organization furnishing the services, facilities or supplies, provided, however, cooperative organizations sponsored by three or more Providers shall not be deemed "related to the Provider."

(b) Common ownership exists when an individual or individuals possess significant ownership or equity in the Provider and the institution or organization serving the Provider.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

1.9.2. Application.

(a) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance and other ways.

(b) Where the Provider obtains services, facilities or supplies from an organization even though it is a separate legal entity, and the organization is owned or controlled by the owner of the Provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities or supplies is lower than the cost to the supplier, the allowable cost to the Provider shall not exceed the market price.

1.9.3. Exception.

An exception is provided to this general principle if the Provider demonstrates by convincing evidence to the satisfaction of the RRC that (i) the supplying organization is a bona fide separate organization; (ii) a substantial part of its business activity of the type carried on with the Provider is transacted with others than the Provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities or supplies furnished by the organization; (iii) the services, facilities or supplies are those which commonly are obtained by institutions such as the Provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and (iv) the charge to the Provider is in line with the charge for such services, facilities or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies. In such cases, the charge by the supplier to the Provider for such services, facilities or supplies shall be an allowable cost.

1.10. Allowance in Lieu of Specific Recognition of Other Costs.

In recognition of the difficulty of measuring all costs of Covered Services, Blue Cross shall pay annually to the Provider as part of its reimbursement hereunder an amount equal to one percent of the Provider's total allowable Blue Cross costs for the then current fiscal year. Payment to Provider shall be made not less frequently than quarterly, at the rate of one-quarter (¼) of the annual amount to be paid Provider with an appropriate adjustment being made at the time of final audit.

1.11. Allowance to Offset Free Care and Bad Debt Losses.

As an offset to the free care and bad debt losses (excluding courtesy discounts) incurred by Providers in furnishing hospital care, Blue Cross shall provide annually during the term of this Agreement, an aggregate annual amount for all Providers listed on Table I below, calculated by multiplying two percent of the listed Providers' total allowable Blue Cross costs, less depreciation and interest, by the ratio of the listed Providers' total allowable Blue Cross costs to total allowable Blue Cross costs, less depreciation and interest, for the then current fiscal year. This aggregate amount shall be allocated to each Provider as provided in Table I below, which has been developed after consideration of each Provider's free care and bad debts, and the resources available to the Provider from sources other than patient payments for such purposes. This allocation shall remain constant throughout the term of this Agreement.

The aggregate amount to be provided for each fiscal year shall initially be established on the basis of the Blue Cross portion of the approved budget costs, and adjusted in each subsequent fiscal year at the time of final settlement. Payment to each Provider shall be made not less frequently than monthly at the rate of 1/12th of the annual amount, with an appropriate adjustment being made at the time of final audit.

TABLE I

Hospitals	*Percent*
Abington	2.25
All Saints	—
Bryn Mawr	3.50

Exhibit C

Hospitals	*Percent*
Bryn Mawr Rehabilitation	—
Chestnut Hill	1.00
Crozer-Chester	11.48
Delaware County	2.71
Doylestown	1.44
Episcopal	6.88
Frankford	4.15
Germantown	4.03
Holy Redeemer	2.71
Jeanes	1.00
Lankenau	3.27
Magee	1.00
Memorial of Roxborough	1.38
Mercy Catholic	13.41
Methodist	5.04
Montgomery	1.76
Nazareth	3.55
Northeastern	3.14
Paoli	2.57
Phoenixville	1.68
Presbyterian	3.96
Riddle	1.06
Sacred Heart General	1.00
Sacred Heart (Norristown)	2.31
St. Christopher's	5.79
St. Joseph's	1.84
Suburban	1.94
Taylor	1.40
West Park	1.00
Wills Eye	1.75
	100.00

Exhibit C

1.12. Payment of Section 1.10 and 1.11 Allowances During Fiscal Year 1977.

The payments provided for in Sections 1.10 and 1.11 shall not become effective until September 1, 1976, but during the period from September 1, 1976 through June 30, 1977, these payments shall be calculated on the basis of a full fiscal year and paid at a quarterly rate equal to 1/3 of the annual amount in the case of the Section 1.10 allowance and at a monthly rate equal to 1/10 of the annual amount in the case of the Section 1.11 allowance, subject in each case to appropriate adjustment at the time of final audit.

Section 2. GENERAL PRINCIPLES OF REIMBURSEMENT.

2.1. Cost Related to Patient Care. (Sec. 405.451)

Principle

All payments to Providers of services must be based on the "reasonable cost" of services covered and related to the care of Subscribers except to Providers which charge on an overall hospital basis less than cost for Covered Services or which elect to be reimbursed for outpatient Covered Services under any of the options provided in subsection 2.4 of this Exhibit A, Part I. Reasonable cost includes all necessary and proper cost incurred in rendering the services, subject to principles relating to specific items of revenue and cost. Any Provider cost for Covered Services which would have been attributable to Part B of Medicare if the case had been covered under Medicare, shall be included.

Exhibit C

2.1.1. Definitions.

(a) The reasonable cost of services is defined as that cost which is allowable under this Agreement. The cost of any services must be determined in accordance with regulations establishing the method to be used and the items to be included. The regulations in this subsection take into account both direct and indirect costs of the Provider. The objective of this subsection is to ensure that reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross. These regulations also provide for the making of suitable retroactive adjustments after the Provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the Provider during the year for Covered Services from both Blue Cross and Subscribers and the amount determined in accordance with an accepted method of cost apportionment to be the actual allowable cost of Covered Services rendered to Subscribers during such year.

(b) Necessary and proper costs are costs which are appropriate and allowable in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the Provider's activity.

(c) Allowable costs are those costs as determined hereunder subject to the limitation set forth in 2.1.2(d) below.

2.1.2. Application.

(a) It is the intent of this Agreement that payments to the Provider should be fair and equitable to both the Provider and Blue Cross.

Exhibit C

(b) The costs of Providers vary from one to another and the variations generally reflect differences in scope of services and intensity of care. The provision for payment of reasonable cost of Covered Services is intended to meet the actual costs, however widely they may vary from one institution to another.

(c) The determination of reasonable cost of Covered Services must be based on costs related to the care of patients. Reasonable cost includes all necessary and proper expenses incurred in rendering Covered Services, such as administrative costs, maintenance costs and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the Provider's operating costs include amounts not related to patient care, or specifically not reimbursable under the Subscription Agreement, such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the Provider will be reimbursed the actual costs of providing quality care however widely the actual costs may vary from Provider to Provider and from time to time for the same Provider.

(d) If Blue Cross wishes to reduce the final payment on the basis that Provider's costs are substantially out of line with the costs of other hospitals in the same area which are similar in size, scope of services, utilization and other relevant factors, or where such factors can be adjusted to meet the criteria of comparability, Blue Cross may appeal directly as provided in Section 20 for such authority, and in such cases Blue Cross shall have the burden of proof. All costs payable pursuant to Section 9 of the Agreement shall be considered in all comparisons made.

Exhibit C

2.2. Determination of Cost of Covered Services to Blue Cross Subscribers. (Sec. 405.452)

Principle

Total allowable costs of a Provider shall be apportioned between Blue Cross Subscribers and other patients so that the share borne by Blue Cross is based upon actual Covered Services received by Subscribers. To accomplish this apportionment, the Provider shall use the departmental method for cost determination unless an alternative method is approved by the Provider and Blue Cross.

2.2.1. Definitions.

(a) Under the departmental method, the ratio of Subscriber charges for Covered Services to total patient charges for the services of each department is applied to the cost of that department.

(b) "Apportionment" means an allocation or distribution of allowable cost between Subscribers and other patients.

(c) "Routine services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(d) "Ancillary services or special services" are the services for which charges are customarily made in addition to routine services.

(e) "Charges" refers to the regular rates for various services which are charged to both Subscribers and other patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services and such charges shall be the same for all classes of patients.

Exhibit C

(f) "Cost" refers to reasonable cost as described in subsection 2.1 hereof.

(g) The ratio of Subscriber charges for Covered Services to total charges on a departmental basis, as applied to inpatients, means the ratio of inpatient charges to Subscribers for Covered Services of a revenue-producing department or center to the inpatient charges of all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of Covered Services rendered to Subscribers is computed by applying the individual ratio for the center to the cost of the related center for the period.

2.2.2. Application.

(a) This Agreement provides that the costs of Covered Services with respect to individuals covered by Blue Cross will not be borne by individuals not so covered, and conversely, that costs with respect to individuals who are not covered by Blue Cross will not be borne by Blue Cross.

(b) The cost of inpatient Covered Services to Subscribers is to be determined by the Provider using the departmental method; the objective of which is to approximate as closely as practicable the actual cost of inpatient services rendered.

(c) Effective July 1, 1977, the cost of outpatient Covered Services to Subscribers shall be determined by the Provider using the departmental method; the objective of which is to approximate as closely as practicable the actual cost of outpatient services rendered.

(d) The method of apportionment for use in determining the cost of Covered Services rendered to Subscribers has as its goal the allocation of total allowable

costs between Subscribers and other patients in as equitable a manner as possible.

2.3 Adequate Cost Data and Cost Finding. (Sec. 405.453)

Principle

Providers receiving payment on the basis of reasonable cost must provide adequate cost data. This will be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding utilizing the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

2.3.1. Definitions.

(a) "Cost finding" is the process of recasting the data derived from the accounts ordinarily kept by a Provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(b) Under the "accrual basis of accounting" revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

2.3.2. Adequacy of Cost Information.

Adequate cost information must be obtained from the Provider's records to support payments made for services rendered to Subscribers. The requirement of adequacy of

data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts, and effective and efficient management of any organization. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

2.3.3. Uniform Accounting Procedures.

Implicit in providing adequate cost information is uniformity in reporting among all hospitals under this Agreement and therefore the Provider and Blue Cross shall comply with the instructions to be issued from time to time to accomplish this as agreed to by the RRC.

2.3.4. Inadequate Data.

If the Provider is unable to furnish adequate data, Blue Cross and the Provider or the RRC will make an appropriate estimate for use in support of payments to be made for Covered Services rendered to Subscribers.

2.3.5. Cost Finding Methods.

After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual cost of services rendered during that period.

(a) *Step-down method.* This method recognizes that services rendered by certain nonrevenue-producing de-

partments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some services from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(b) *Other methods*—(i) *Double-apportionment method.* The double-apportionment method may be used by the Provider upon approval of Blue Cross or the RRC. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as the revenue-producing centers. A preliminary allocation of the costs of the nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing centers directly to the revenue-producing centers. However, having elected to

use the double-apportionment method, the Provider may not thereafter use the step-down method without approval of Blue Cross or the RRC.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the Provider upon approval of Blue Cross or the RRC. Request for the approval of such methods must be made on a prospective basis and submitted before the end of the first quarter of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the Provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

2.4. Payments to Providers. (Sec. 405.454)

Principle

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Interim payments approximating the actual cost of the Provider will be made on the most expeditious basis administratively feasible. A retroactive adjustment based on actual costs will be made at the end of the reporting period and an appropriate payment made by either Blue Cross or the Provider to correct any overpayment or underpayment. At the request of Provider, payment will be made on the basis designed to reimburse currently for Covered Services rendered to Subscribers.

2.4.1. Amount and Frequency of Payment.

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Since actual costs of Covered Services cannot be determined until the end of the accounting period, the Provider must be paid on an estimated cost basis during the year. Interim pay-

ments shall be made no less often than semi-monthly on the most expeditious basis administratively feasible. The estimated cost basis for determining interim payments during the year shall be based on one hundred percent of the Provider's budget submitted in accordance with Section 24 of this Agreement, as approved by the RRC, so that the retroactive adjustment based on actual costs will be as small as possible.

2.4.2. Interim Payments.

(a) The gross interim inpatient per diem rates of payment will be determined based on the Provider's budget as submitted and approved in accordance with Section 24 of the Agreement. This interim rate of payment may be adjusted by the RRC during the applicable accounting period if the Provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the RRC may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(b) Outpatient interim rates, including the SPU, will be a percentage of charges based on outpatient costs and charges information of the Provider and calculated using the Provider's budget as submitted and approved in accordance with Section 24 of the Agreement, or the latest submitted cost report.

2.4.3. Determination of Interim Payments to Providers.

Inpatient interim payments will be determined using the gross inpatient per diem cost multiplied by the number of days of Covered Services, less any co-payment or deductible.

Example: On a six day stay under the Co-Pay Comprehensive Subscription Agreement with the following, arbitrarily chosen amounts, the remittance would be calculated as follows:

Gross Per Diem Cost	$ 60.00
Multiplied by:	
Blue Cross Covered Service Days	×6
	$360.00
Less:	
Co-Payment: 6 days at $5.00 per day	30.00
Remittance to Provider	$330.00

2.4.4. Retroactive Adjustment.

(a) At the end of a quarterly reporting period, a retroactive adjustment will be made to bring the interim payments made to the Provider during the period into agreement with the reimbursable amount payable to the Provider for the Covered Services rendered to Subscribers during that period.

(b) In order to reimburse the Provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received and the desk review completed. For this purpose, the cost report will be accepted as filed unless there are obvious errors or inconsistencies—subject to later audit. Any dispute will be resolved by the RRC. The amount determined as a result of the desk review shall be payable in full within twenty days following such review to either the Provider or Blue Cross, as appropriate. When a final audit is made and the Providers allowable cost hereunder is determined, a final payment will be made by either the Provider or Blue Cross, as appropriate.

(c) To determine the retroactive adjustment, the amount of the Provider's total allowable reasonable cost

apportioned to Blue Cross for the reporting year is computed. This is the total amount of cost reimbursement the Provider is due to receive from Blue Cross and Subscribers for Covered Services rendered during the reporting period. The total of the interim payments made by Blue Cross in the reporting year and the deductibles and coinsurance amounts receivable from Subscribers is next computed. The difference between the reimbursement due and the sum of payments made by Blue Cross and amounts payable by Subscribers is the amount of the retroactive adjustment. Any dispute as to the amount of the Provider's total allowable reasonable cost shall be resolved by the RRC.

2.4.5. Providers which Charge Less in the Aggregate than Total Payments received from Blue Cross under this Agreement.

Payments to a Provider which on an overall hospital basis charge less in the aggregate for inpatient Covered Services than the total payments received from Blue Cross pursuant to this Agreement for inpatient Covered Services will be reimbursed based on charges and related to the percentage of total Blue Cross inpatient days in such institutions in the following manner:

If less than ten percent of the total Blue Cross inpatient days occur in hospitals which charge less in the aggregate than the total payments received from Blue Cross pursuant to this Agrement, payment to such Providers shall be one hundred percent of charges for Covered Services. For each five percent increase in the percentage of total Blue Cross inpatient days which occur in hospitals which charge less in the aggregate than the total payments received from Blue Cross pursuant to this Agreement, in excess of the first ten percent, the percent of charges paid to such hosiptals shall be decreased one

percent. The payment to such hospitals, however, shall never be less than ninety-five percent of charges.

2.4.6. Provision for Current Reimbursement.

Based on the premise that (i) payment for Subscriber Covered Services should be constructively received by the Provider as promptly as possible following the patient's discharge and (ii) it is a reasonable expectation that the Provider will promptly complete and submit Subscriber bills within seven days after discharge and Blue Cross will process such bills within six days after receipt, with an allowance of two days for mail deliveries, or a total of fifteen days, Blue Cross shall make available the following programs:

(a) In addition to the basic procedure for reimbursement, Blue Cross will, upon request by the Provider, make an advance payment in an amount equal to the sum of the following:

(i) The number of Subscriber inpatient discharges during an average fifteen day period multiplied by the Provider's projected average Blue Cross payment per case based on the approved budgeted data and actual experience in the most recent available fiscal year;

(ii) Average daily outpatient payments to the Provider by Blue Cross in the most recent available fiscal year, multiplied by fifteen; and,

(iii) Average daily maternity, nursery and Medicare supplementary indemnity payments to the Provider by Blue Cross in the most recent available fiscal year, multiplied by fifteen.

The above calculation will be updated by Blue Cross upon receipt from the Provider of the current data required by Section 24 of the Agreement. In the event any

advances currently outstanding differ from the amount determined by such recalculation, Blue Cross will appropriately increase or decrease the outstanding advance within ninety days thereafter.

(b) In the event the Provider is unable to promptly complete its billing procedure, the Provider may, at any time request, subject to Blue Cross approval, a supplementary advance equal to that provided in subsection (a) above. The Provider will pay to Blue Cross interest on the outstanding balance of any supplementary advance at the annualized rate of one and one quarter percent above the prime rate of interest charged by Philadelphia National Bank on the last working date of each month. Such interest shall be calculated monthly and deducted from succeeding daily remittances being considered interest paid for borrowed working capital. The supplementary advance shall be repaid by the Provider to Blue Cross on mutually acceptable terms, but in no event shall any supplementary advance, in whole or part, remain outstanding beyond the last day of the stated term of this Agreement.

(c) Blue Cross shall submit, upon request, any and all data the Provider may require to determine the allowable amounts hereunder.

(d) If the Provider has elected the optional Periodic Interim Payment method, described in subsection 2.4.7 below, it shall not be eligible for the advances permitted by this subsection.

2.4.7. Optional Periodic Interim Payment.

In lieu of the payment procedure described in subsection 2.4.6 above, Provider may elect the Periodic Interim Payment method of reimbursement (as described in current Medicare regulations as such may exist from time to time hereafter) if such election is made in writing

and delivered to Blue Cross within 15 days following the execution of this Agreement for the first fiscal year hereof, and in subsequent years at least 30 days prior to the beginning of the fiscal period. In the event such election is made all current reimbursement then outstanding shall be repaid to Blue Cross within 60 days following the date of such election, or as otherwise agreed by the Provider and Blue Cross.

2.4.8. Cost Reporting Period.

Blue Cross will require submission of reports of operations based upon the Provider's accounting year within 120 days of the close of the Provider's fiscal year, subject to the same late filing restrictions on subsequent reimbursement as are applicable for failure to file like reports under then Medicare regulations.

2.4.9. Reporting Budgeted Cost of Whole Blood.

Provider shall submit to Blue Cross and RRC upon request, or at the time of the annual budget submission, the annual cost budgeted by the Provider for whole blood.

PART II. PROSPECTIVE RATE BASIS.

If the Provider elects to be reimbursed on a prospective rate basis, it shall submit the material required for budgetary review as provided in Section 24 of the Agreement. Using this material and other data which it may request, Blue Cross and the Provider shall prospectively establish a fixed gross inpatient per diem rate or annual rate of reimbursement which shall be based on the principles set forth in Part I of this Exhibit A.

1. Inpatient Services.

The Provider shall be reimbursed for inpatient Covered Services provided to Subscribers based on the

prospective rate which shall be determined to the mutual satisfaction of Provider and Blue Cross in accordance with the terms and limitations set forth in Section 24 of this Agreement. In the event Provider is reimbursed for inpatient Covered Services in accordance with this Part II, those principles set forth in Part I of this Exhibit A which apply to reimbursement for inpatient services shall not alter or modify such fixed prospective rate, but in the case of gross inpatient per diem rates the computation of inpatient claims shall be made in the manner as provided in subsection 2.4.3 "Determination of Interim Payment to Providers" of Exhibit A, Part I, and such payments shall be final payment. No retroactive adjustment to such payments shall be made on the basis of actual cost except as otherwise provided in Section 24 of this Agreement.

2. Outpatient Services.

In determining the payments for outpatient services to be made to a Provider who has elected to be reimbursed on a prospective rate basis, payment will be made to the Provider pursuant to subsection 2.4 or on a prospective rate agreed to in advance by Blue Cross and the Provider. The foregoing election shall be binding upon the Provider for the fiscal year covered by such prospective rate, but may be changed when a new prospective rate is established for a subsequent fiscal year.

3. Other Requirements.

Providers electing to be reimbursed on the prospective rate basis shall be subject to all the provisions in this Agreement except where specifically stated otherwise in this Part II of this Exhibit A or elsewhere in this Agreement.

EXHIBIT B

OPERATING BUDGET

INSTRUCTIONS

Introduction

The budget forms were prepared by the Joint Blue Cross-Hospital Council Task Force on Budget Review.

The form and content includes the information necessary for conformity with the new Blue Cross "Hospital Agreement" under provision section 24 "Budgetary Review Procedure."

SECTION 24. *Budgetary Review Procedures.*

24.2. Submission and Review of Budget.

Each Provider shall submit its annual budget to the RRC not later than the May 15th prior to the beginning of each fiscal year on the standard form attached hereto as Exhibit B, which may from time to time be modified by the RRC as prescribed by the RRC. The budget as submitted shall have the prior approval of the Provider's governing board or its financial committee charged with the responsibility of preparing such material. The budget shall also contain an explanation of any unusual factors affecting the Provider's cost, such as, but not limited to, changes in patient mix, volume and new or reduced services. The RRC shall review the data submitted by Provider in accordance with the provisions of Exhibit A utilizing the following procedures:

24.2.1. If the RRC shall determine that the budget is reasonable and correct, it shall so advise the Provider and Blue Cross utilizing the gross inpatient per diem rate proposed by the Provider in its budget as the basis for interim reimbursement for patient days during such budgeted fiscal year.

24.2.2. If the RRC questions the reasonableness of the interim rate proposed in the budget, the RRC shall, within 30 days of receipt of the budget, so advise Provider and request additional data and a meeting with the Provider's representatives, as indicated. The RRC shall promptly forward a report of the interim rates it has found reasonable to Blue Cross.

24.2.3. If the RRC is unable to reach a majority decision as to the interim rate, it shall be joined by an arbitrator from the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. In the event of any such disagreement, and until a final decision is rendered, the interim rate to be paid by Blue Cross shall be the rate indicated in the submitted budget, unless the Provider advises Blue Cross it desires a lower rate be used for interim reimbursement. Following entry of a decision, the interim rate will be adjusted retroactively and any overpayment or underpayment, together with interest thereon, at an annualized rate of one and one quarter percent above the prime commercial rate charged by the Philadelphia National Bank during such period, shall be paid or refunded by Blue Cross or Provider as appropriate.

Statistical definitions shall conform to the A.H.A. "Uniform Hospital Definitions," dated 1960.

Providers are required to enter their name, Blue Cross Code Number and the applicable dates on each page in the spaces provided, also enter applicable dates in the headings, "Actual, Projected and Budget."

Budget Forms

A. Summary of Costs

B. Calculation of Tentative Blue Cross Gross Payment Rate

C. Departmental Summary and Per Diem Calculation

D. Statistics

E. Salaries & Wages-Employees & Fees

F. Supplies & Expenses

G. Depreciation Expense

H. Analysis of Recovery of Expense Items

I. Personnel Policies

J. Supplemental Questionnaire

K. Comparative Report Educational Expenses

Filing Date

Budget forms should be prepared and submitted no later than the May 15th prior to the beginning of the fiscal year.

Number of Copies Required

All forms should be completed and filed in *duplicate.* (Typing not required, but must be legible copy.)

Actual Expenses

Should represent actual expenses for the first complete preceding fiscal year.

Projected Expenses

Provider should indicate the number of months of actual expenses (minimum of six months) and the number of months of estimated expenses in the current fiscal year.

Instructions for Completing Budget Forms

Form A—Self-explanatory.

Form B—Self-explanatory.

Exhibit C

Form C—Departmental Summary and Per Diem Calculation:

(1) Detailed figures reported should be budgeted figures only.

(2) Amounts reported as Salaries & Wages-Employees & Fees, Supplies & Expenses and Depreciation should agree in total with the amounts reported on the budgeted detailed expense schedules (Forms E, F, and G).

(3) The per diem amounts should be based on the total budgeted patient days as reported on Form D.

(4) The paid hours should agree with the total of hours as reported on the detailed Form E.

(5) The requested operating statistics should be completed in accordance with the detailed notes on Form C, Page 5 and should be based on the amounts and hours as reported on Form C.

Form D—The regularly maintained number of beds represents the *average* number of beds available, set up and staffed for use during the applicable year.

Form E—Salaries & Wages-Employees & Fees:

(1) The number of full-time equivalent employees (FTE) should be determined by dividing the paid hours by 2080 annual hours per employee.
The number of salaried employees, and/or physicians on a fee basis for

Exhibit C

which paid hours are not recorded shall be included in the FTE, calculated by adding 2080 hours for each such full-time person and the part of 2080 hours represented by the percent of time spent in hospital activities for each such part-time person.

(2) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(3) The total amount on Page 7, Line 93 should be carried forward to Form A, Line 1.

Form F—Supplies & Expenses:

(1) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(2) The total amount on Page 7, Line 91 should be carried forward to Form A, Line 2.

(3) The total amount of interest expense on Page 7, Line 94 should be carried forward to Form A, Line 4.

Form G—Depreciation Expense:

(1) For Blue Cross purposes, only straight line method of depreciation is permitted.

(2) The total amount of depreciation on Form G, Line 9 should be carried forward to Form A, Line 3.

Exhibit C

Form H—Analysis of Recovery of Expense Items:

(1) The totals on Form H, Line 16 should be carried forward to Form A, Line 6.

Form I—Self-explanatory.

Form J—Self-explanatory.

Form K—Comparative Report Educational Expenses:

The purpose of this Form is to identify the amount of educational expense.

(1) Salaries and fees are the totals including those charged directly to the teaching program, to various cost centers, etc. Portions of salaries and fees paid to those individuals which are not related to intern and residence programs are to be excluded.

(2) Fringes and/or perquisites are those which are *not* furnished all other employees; e.g. value of living accommodations, meals, laundry, drugs, use of automobile, etc., but excluding malpractice insurance.

Exhibit C

FORM A

Date Submitted: _____

B. C. Code No. _____

OPERATING BUDGET
Summary of Costs

(HOSPITAL)

Fiscal Year: _____

	ACTUAL		PROJECTED		BUDGET		Percentage Variances	
TOTAL OPERATING EXPENSES	Amount	%	Amount	%	Amount	%	Projected to Actual	Budget to Projected
1. Salaries & Wages—Employees & Fees (From Form E, line 93)	$		$		$		%	%
2. Supplies & Expenses (From Form F, line 91)								
3. Depreciation (From Form G, line 9)								
4. Interest on Indebtedness (From Form F, line 94)								
5. TOTAL Expenses		100%		100%	$	100%		
Less Deductions and Recoveries								
6. Items of Income which are recovery of expenses (From Form H, line 24)								
7. Less: Research (From Form E, line 91 plus Form F, line 75)								
8. Less: Non-Reimbursable Functions (From Form E, line 92 plus Form F, line 76)								
9. Less: Home Care (From Form E, line 69 plus Form F, line 52)								
10. Less: Extended Care (From Form E, line 39 plus Form F, line 51)								
11. Less: Other: (Explain)								
12.								
13.								
14. TOTAL Deductions	$		$		$			
15. TOTAL Patient Care Expenses Net	$		$		$			

I certify that this Budget has been reviewed and approved by the governing body of this institution.

_____ (Date) _____ (Signature) _____ (Title)

Exhibit B

OPERATING BUDGET
Calculation of Tentative Blue Cross Gross Payment Rate

FORM B

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

92a

Fiscal Year: _____

	ACTUAL	PROJECTED	BUDGET	Percentage Variances: Projected to Actual	Percentage Variances: Budget to Projected
1. Total Patient Care Expenses Net (Form A, line 15)	$	$	$	%	%
2. Less: Out Patient Expenses (Note 1)					
3. Total In Patient Expense (Line 1 — line 2)					
4. Total In Patient Days (Excluding Newborn)					
5. TOTAL Average Per Diem In Patient Expenses (Line 3 ÷ line 4)	$	$	$		
	$	$	$		

Note 1 — Out Patient expenses to be calculated on the ratio of the provision: gross out patient expenses to total expenses per Blue Cross Cost Report Schedule C applied to Line 2 above.

Exhibit C

B-5

(Form B)

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 1 of 5

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS: Salaries & Wages—Employees and Fees — Amount	Salaries & Wages—Employees and Fees — Per Diem	Supplies & Expenses (Forms F & G) — Amount	Supplies & Expenses (Forms F & G) — Per Diem	Budgeted Total Costs — Amount	Budgeted Total Costs — Per Diem	Paid Hours (Form E)	Operating Departmental Statistics
1. ADMINISTRATIVE AND GENERAL								
Executive offices	$	$	$	$	$	$		
Accounting & Fiscal								
All other Administrative Expenses								
TOTAL	$	$	$	$	$	$		
Direct Cost Per Bed (note 1)								
Manhours Per Bed (note 2)								
2. DIETARY								
Number of Meals Served								
Direct Cost Per Meal								
Meals Served Per Manhour								
3. PLANT								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								
4. HOUSEKEEPING								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								

Exhibit C

B-6

(Form B)

93a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 2 of 5

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Department Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
5 MAINTENANCE OF PERSONNEL	$	$	$	$	$	$		
6 LAUNDRY AND LINEN								
Laundry Direct Cost Per 100 lbs.								
Laundry lbs. Per Manhour								
Laundry lbs. Per Patient Day								
Laundry and Linen D. C. Per Bed (note 1)								
7 TOTAL NURSING SERVICE								
OB Manhours Per Bed Per Day (note 3)								
Med. Surg. Manhours Per Bed Per Day (note 3)								
All other Manhours Per Bed Per Day (note 3)								
TOTAL Nursing Manhours Per Bed Per Day (note 3)								
8 CENTRAL STERILE SUPPLY								
Direct Cost Per Bed (note 1)								
9 DELIVERY ROOM & POST PARTUM RECOVERY								
Number of Deliveries								
Direct Cost Per Delivery								
Manhours Per Delivery								
10 OPERATING ROOM & CYSTOSCOPY								
Number of Operations								
Direct Cost Per Operation								
Manhours Per Operation								

Exhibit B

Exhibit C

94a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 3 of 5

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Department Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
11 RECOVERY ROOM	$	$	$	$	$	$		
12 LABORATORY								
13 BLOOD BANK								
14 X-RAY DEPT. INCLUDING X-RAY THERAPY, AND ISOTOPE THERAPY								
Manhours per procedure								
Direct cost per procedure								
15 PHARMACY								
16 MEDICAL RECORDS AND LIBRARY								
Direct cost per bed (note 1)								
Manhours per bed (note 2)								
17 ANESTHESIOLOGY								
18 INHALATION THERAPY								
19 EMERGENCY ROOM								
20 AMBULANCE SERVICE								
21 CLINICS								

Exhibit B

Exhibit C

95a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
22. ALL OTHER PROFESSIONAL SERVICES	$	$	$	$	$	$		
Physical Therapy								
Social Service								
Home Health Care								
Day Nursery								
Electrocardiograph								
Electroencephalograph								
Medical Photography & Illustration								
Speech Therapy								
Occupational & Recreational Therapy								
Extended Care								
23. MEDICAL EDUCATION								
(should agree with Form K, line 13)								
24. PARA-MEDICAL EDUCATION								
School of Nursing (R.N.)								
Other Education								
Direct Cost Per Bed (note 1)								
25. RESEARCH EXPENSES								
26. NON-REIMBURSABLE FUNCTIONS								

Exhibit B

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Exhibit C

96a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
27. NON-DEPARTMENTAL EXPENSES	$	$	$	$	$	$		
Payroll Taxes								
Fire, Liability, Malpractice & Other Insurance								
Group Life								
Hospitalization								
Major Medical								
Workmens Compensation								
Unemployment Insurance								
Tuition Refund								
Pension Costs								
Taxes Other than Payroll								
Other								
Interest—Capital Debt								
Interest—Working Capital Debt								
Depreciation and Leases								
28. TOTAL (should agree with amounts reported on Forms E, F, & G)								

Exhibit C

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Note 1—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total budgeted costs.

Note 2—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total paid hours.

Note 3—This is a daily statistic and is calculated by multiplying the total number of regularly maintained beds by 365 days and dividing the result into the total paid hours.

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Exhibit B

NOTE: Refer AHA Uniform Definitions (1963) for explanation of statistical terms.

OPERATING BUDGET
Statistics

FORM D
Page 1 of 3

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	Number of Beds Regularly Maintained	Total Patient Admissions	Total Patient Days	Average Length Of Stay	Percent Occupancy
Actual _____					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Projected ____ ____ Months Actual ____ Months Estimated					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Budget _____					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					

Exhibit D

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OPERATING BUDGET
Statistics

FORM D
Page 2 of 3

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Service	Total	Inpatients	%	Outpatients	%
Laboratory Operations					
Clinical Lab Test:					
Actual _____					
Projected _____					
Budget _____					
Pathological Exams:					
Actual _____					
Projected _____					
Budget _____					

Radiological Operations					
Diagnostic X-Ray Procedures					
Actual _____					
Projected _____					
Budget _____					
Therapeutic X-Ray Procedures					
Actual _____					
Projected _____					
Budget _____					
Radio-Isotope Procedures					
Actual _____					
Projected _____					
Budget _____					

Exhibit B

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Exhibit C

99a

OPERATING BUDGET
Statistics

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Clinic Stastistics	Number of Clinics Operated	Total Clinic Hours Scheduled Weekly	Number of Visits Annually	No. of Patients Treated Annually
Actual ____				
Projected ____				
Budget ____				

Private Ambulatory Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Emergency Room Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Number of Operations	Total Number
Actual ____	
Projected ____	
Budget ____	

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
1. A. SERVICE DEPARTMENTS									
2. Administrative & General:									
3. Executive Offices									
4. Accounting and Fiscal Services									
5. All Other Administrative									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13. TOTAL Administrative & General									
14.									
15. Dietary (including Cafeteria)									
16.									

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
17.	PLANT:									
18.	Maintenance									
19.	Operation of Plant									
20.	Motor Service									
21.	Security									
22.	TOTAL Plant									
23.										
24.	Housekeeping									
25.	Maintenance of Personnel (Personnel Quarters)									
26.										
27.	Laundry									
28.	Linen, Bedding & Sewing Room									
29.	TOTAL Service Departments									

Exhibit B

Exhibit C

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OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
30.	B. PROFESSIONAL CARE OF PATIENTS									
31.	Nursing Service:									
32.	Nursing Service Administration									
33.	Obstetrics									
34.	Medical and Surgical									
35.	Intensive Care & Coronary Care Units									
36.	Pediatrics									
37.	Nursery									
38.	Psychiatric									
39.	Extended Care									
40.										
41.										
42.	TOTAL Nursing Service									
43.										
44.	Central Sterile Supply									

Exhibit B

Exhibit C

103a

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
45	Delivery Room & Post Partum Recovery									
46	Operating Room & Cystoscopy									
47	Recovery Room									
48										
49	Laboratories									
50	Blood Bank									
51	Medical Photography & Illustration									
52	Diagnostic X-Ray									
53	X-Ray Therapy									
54										
55	Radio—Isotopes									
56	Renal Dialysis									
57										
58	Pharmacy									
59	Medical Records									

Exhibit C

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
60.	Medical Library									
61.	Anesthesiology									
62.	Inhalation Therapy									
63.	Electroencephlagraph									
64.	Electrocardiograph									
65.										
66.	Physical Therapy									
67.	Speech Therapy									
68.	Occupational & Recreational Therapy									
69.	Home Health Care									
70.	Social Service									
71.	Emergency Room									
72.	Clinics									
73.	Ambulance Service									

Exhibit C

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ___ Months Actual ___ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
74										
75										
76										
77										
78										
79	TOTAL Professional Services									
80	Medical Education (should agree with Form K, line 13)									
81										
82	C. PARA-MEDICAL EDUCATION									
83	School of Nursing									
84	School of Practical Nursing									
85	In-Service Education									
86	School of Medical Technology									

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Exhibit B

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ___ Months Actual ___ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
87.	School of X-Ray Technology									
88.										
89.										
90.	TOTAL Para-Medical Education									
91.	Research									
92.	Non Reimbursable Functions									
93.	TOTAL Salary & Wages—Employees & Fees (To Form A, line 1)	$			$			$		

R-2(1)

Exhibit C

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Exhibit B

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 1 of 7

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
1 SERVICE DEPARTMENTS			
2 Executive			
3 Accounting & Fiscal			
4 All other Administrative			
5 TOTAL Administrative			
6 Dietary (including Cafeteria)			
7 Plant			
8 Housekeeping			
9 Maintenance of Personnel (Personnel Quarters)			
10 Laundry			
11 Linen, Bedding & Sewing Room			
12			
13			
14 TOTAL Service Departments			
15			

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Exhibit C

106a

Exhibit B

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 2 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
16. PROFESSIONAL CARE OF PATIENTS:			
17. Nursing Service			
18. Central Sterile Supply			
19. Delivery Room & Post Partum Recovery			
20. Operating Room & Cystoscopy			
21. Recovery Room			
22. Laboratories			
23. Blood Bank			
24. Medical Photography & Illustration			
25. Renal Dialysis			
26.			
27.			
28.			
29. Diagnostic X-Ray			
30. X-Ray Therapy			
31.			

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Exhibit C

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Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
32.	Radio—Isotopes			
33.				
34.				
35.				
36.	Pharmacy			
37.				
38.	Medical Library			
39.	Medical Records			
40.				
41.				
42.	Anesthesiology			
43.	Inhalation Therapy			
44.	Electroencephalograph			
45.	Electrocardiograph			
46.				

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
47.	Physical Therapy			
48.	Speech Therapy			
49.	Social Service			
50.	Occupational and Recreational Therapy			
51.	Extended Care			
52.	Home Health Care			
53.	Emergency Room			
54.	Ambulance Service			
55.	Clinics			
56.				
57.				
58.				
59.				
60.				
61.				

Exhibit C
110a
Exhibit C
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OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED Months Actual Months Projected	BUDGET
62. Medical Education (should agree with Form K, line 13)			
63.			
64.			
65. TOTAL Professional Care of Patient Expenses			
66. PARA-MEDICAL EDUCATION:			
67. School of Nursing			
68. School of Practical Nursing			
69.			
70. In-Service Education			
71. School of Medical Technology			
72. School of X-Ray Technology			
73.			
74. TOTAL Para-Medical Education			
75. Research Expenses			

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED Months Actual Months Projected	BUDGET
76. Non Reimbursable Functions			
TOTAL DEPARTMENTAL EXPENSES (Lines 1-76)			
NON-DEPARTMENTAL EXPENSES			
77. Payroll Taxes			
78. Fire, Liability, Malpractice & Other Insurance			
79. Group Life			
80. Hospitalization			
81. Major Medical			
82. Workmen's Compensation			
83. Unemployment Insurance			
84. Tuition Refund			
85. Pension Costs			
86. Taxes Other than Payroll			
87. Other			

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
88.			
89.			
90. TOTAL NON-DEPARTMENTAL EXPENSES			
91. TOTAL SUPPLIES & EXPENSES (To Form A, line 2)			
92. Interest Expense—Capital Indebtedness			
93. Interest Expense—Working Capital Indebtedness			
94. TOTAL INTEREST EXPENSE (To Form A, line 4)			

Note: Indicate Cost Center to which IV's are charged.

FORM G

OPERATING BUDGET
Depreciation Expense

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

	____ ACTUAL		____ PROJECTED		____ BUDGET	
	Method	Amount	Method	Amount	Method	Amount
1 Land Improvements		$		$		$
2 Buildings						
3 Fixed Equipment						
4 Automobiles and Trucks						
5 Major Movable Equipment						
6 Leasehold Improvements						
7 Minor Equipment						
8 Other						
9 TOTAL (To Form A, Line 3)		$		$		$

OPERATING BUDGET
Analysis of Recovery of Expense Items

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
1 Telephone service (pay stations excluded)	$	$	$
2 Radio & television serv			
3 Laundry & Linen Serv			
4 Vending Machines Commission			
5 Employee and guest meals			
6 Sale of drugs to other than patients			
7 Sale of medical & surgical supplies to other than patients			
8 Sale of medical records and abstracts			
9 Sale of scrap, waste, etc			
10 Rental of quarters to employees and others			
11 Rental of hospital space			
12 Payments received from specialists			
13 Trade, quantity, time, and other discounts on purchases			

Exhibit B

OPERATING BUDGET
Analysis of Recovery of Expense Items

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
14 Rebated and refunds of expenses	$	$	$
15 Gift, flower, and coffee shops			
16 Nursing School (tuition, fees, textbooks, uniforms, etc.)			
17 Grants, gifts, and income designated by the donor for specific expenses			
18 Recovery of insured loss			
19 Fund raising expenses			
20 Other (Specify)			
21 Other (Specify)			
22 Other (Specify)			
23 Other (Specify)			
24 Total (To Form A, line 6)	$	$	$

Exhibit B

OPERATING BUDGET
Personnel Policies

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate the current minimum hiring wage your institution is paying for unskilled labor.

RATE $ _____

2. Are there any plans to increase the above minimum wage during the budgeted period, please explain below.

_____

_____

_____

_____

3. Indicate the beginning rate on July 1 of budgeted year for the following personnel classifications.

Interns	$	Annually
Residents		Annually
Registered Nurses		Annually
Licensed Practical Nurses		Annually
Nursing Aides		Hourly
Orderlies		Hourly

4. Does the hospital provide any housing for employees? Indicate type of housing, number of units, any income, etc.

_____

_____

5. On what date do your employees receive their annual merit adjustments, i.e., employment anniversary, July 1, other ?

_____

6. Outline briefly union contracts in force. Include names of unions, number of employees in each bargaining unit and expiration date of contracts.

_____

_____

_____

_____

OPERATING BUDGET
Personnel Policies

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

7. Nursing Service Complement

	FTE.	Percent
RN's		
LPN's		
Aides		
All Other Nursing Personnel		
TOTAL—Per Form E, line 42		100%

8. How many hours constitute the regular work week? _____

Briefly explain the following policies of your hospital; or submit a copy of your personnel policies.

9. Premium Pay — Overtime _____
— On call pay _____
— Shift differential _____
— Call back Allowance _____

10. Number of holidays granted each year _____

11. Briefly explain vacation policy. _____

_____

_____

12. Employee benefits (indicate whether contributory or non-contributory) _____

_____

13. Sick leave benefits _____

_____

OPERATING BUDGET
Supplemental Questionnaire

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate by check those services or programs in which you participate

	YES	NO
H.A.S. (Hospital Administrative Services)		
P.A.S. (Professional Activity Study)		
M.A.P. (Medical Audit Program)		
P.A.T. (Pre-Admission Testing)		
OB/GYN mixing		
H.U.P. (Hospital Utilization Program)		
S.P.U. (Short Procedure Unit)		
M.C.U. (Minimal Care Unit)		

2. Indicate status of prior years cost filings with third parties (not amounts due) where final settlement has not been completed

Year	Blue Cross	Medicare	Medicaid

3. Indicate any service contracts which the hospital has for the performance of Patient Care Services, Data Processing, Dietary, Housekeeping, Laundry, etc.

_____

_____

_____

_____

Exhibit B

Exhibit C

120a

OPERATING BUDGET
Supplemental Questionnaire

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

4. Indicate any rentals and leases in excess of $5,000 per annum

_____

_____

_____

_____

_____

5. List new facilities, leases, programs or services, since July 1, 1975. Indicate the approximate annual direct costs and whether approval of an appropriate Planning Agency, if necessary was obtained

_____

_____

_____

_____

_____

6. Do you have approved intern and residency programs? ☐ yes ☐ no If yes, please list below

_____

_____

_____

_____

_____

7. Please attach a copy of most recent audited Financial Statement

8. List hospital based ancillary services which bill separately from hospital billing

_____

_____

9. Indicate name of public accounting firm employed by hospital for the budget year

_____

_____

Exhibit B

Exhibit C

121a

Exhibit C

FORM E

OPERATING BUDGET
Comparative Report Educational Expenses

Date Submitted: _____
B. C. Code No. _____

(HOSPITAL)

Fiscal Year: _____

PERSONNEL: Number F.T./P.T.	ACTUAL				PROJECTED				BUDGET				Percentage Variance Budget vs.	
	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Actual	Proj.
1 Interns	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
2 Residents	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
3 Director Med. Ed.	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
4 Secy. & Clerks	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
5 Teaching M.D.'s	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
6 Others	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
7 Total Expenses	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
EXPENSE OFFSETS														
8 Grants	$													
9 Fellowships	$													
10 Income-Affiliates	$													
11 Others	$													
12 Total Offsets	$													
13 Total Net Expenses	$													

Exhibit C

Exhibit C

EXHIBIT C

HOSPITAL SAFETY PROGRAM

In accordance with Section 16 of this Agreement, the Provider agrees to establish a safety program incorporating, as practicable and appropriate, the following principles:

1. Management Involvement.

(a) The basic program shall incorporate procedures designed to foster loss control and malpractice prevention, and shall be communicated in written form to key hospital personnel.

(b) Plans to implement the program and periodic progress reports shall be included on the agenda of top level management meetings.

(c) A Safety Committee shall be formed to include at least one trustee, administrative personnel, at least one physician, and other appropriate persons.

2. Education.

(a) The Safety Committee shall review incidents threatening the safety of patients.

(b) The Provider shall instruct medical personnel as regards the nature and legal implications of malpractice.

3. Policies and Standards for Reporting Incidents.

All incidents or unusual occurrences threatening the safety of patients shall be reported in writing to the chief administrative officer, or his designee, and the Safety Committee.

4. Accident Investigation.

The chief administrative officer, or his designee, shall make prompt investigation of all non-medical incidents and the chief medical officer, or his designee, shall inves-

tigate all medical incidents. The Safety Committee shall take appropriate steps to prevent assertions of malpractice and develop appropriate policies to implement such practice.

5. **Facility Inspections.**

The chief administrative officer, or his designee, shall inspect Provider's facilities regularly giving particular attention to equipment involved in critical patient care. All deficiencies or malfunctions shall be reported along with the corrective action taken. Medical personnel shall be designated to periodically inspect equipment involved in critical patient care.

6. **Supervisory Training.**

Procedures shall be established for the training of not only supervisory personnel, but all employees shall be included in the safety program.

7. **Group Meetings.**

Safety meetings shall be held periodically by each department of the Provider.

8. **Personnel Protection.**

The Provider shall provide protective equipment to appropriate personnel and ensure that such is periodically inspected.

9. **Contract Review.**

Purchasing arrangements, including arrangements for the purchase of drugs being used for experimental purposes, shall be carefully reviewed to ensure that suppliers have assumed responsibility for inherent defects in their products.

10. **Other Loss Control Programs.**

Programs shall be established to control and eliminate fire hazards, workmen's compensation losses, liability losses and other types of avoidable expenses.